REPORT OF THE COMMITTEE TO REVIEW THE MEDICAL CARE PROGRAM

COMMITTEE ON MEDICAL CARE
MARYLAND STATE PLANNING COMMISSION

FEBRUARY 1953

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MARYLAND STATE PLANNING COMMISSION

February 16, 1953

Honorable Theodore R. McKeldin
Governor of Maryland
and
Honorable Members
General Assembly of Maryland

Gentlemen:

I take pleasure in transmitting herewith for your consideration and review the "Report of the Committee to Review the Medical Care Program".

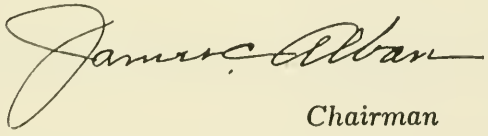
The Committee, functioning as part of the State Planning Commission's Committee on Medical Care, has completed its study of the efficiency, costs, and social implications of the Medical Care Program of Maryland, in keeping with Governor McKeldin's request of August 29, 1951, and Senate Resolution No. 22 of the 1951 General Assembly.

The present document combines two separate submissions by the Committee. Report No. 1, entitled "A Review of the Medical Care Plan of Maryland", covers the Program in Maryland's twenty-three counties. This section was approved at the meeting of the Committee on Medical Care, held on December 5, 1952. Report No. 2, entitled "Review of the Medical Care Plan of Baltimore City", was approved by the Committee on Medical Care, at its meeting on February 13, 1953.

On behalf of the Commission, I want to express our deep appreciation to the Honorable Joseph Sherbow, who served as able Chairman, and to the members of his Committee, who with him contributed unselfishly their time and effort toward the successful completion of this survey. Special appreciation is also due the Committee on Medical Care, who through its Office of Studies, rendered valuable assistance in the preparation of the Report.

I would like to acknowledge also the interest and encouragement given by the Governor and the members of the Legislature during the course of this study, which affects the health and well-being of citizens in every part of the State of Maryland.

Respectfully submitted,



Chairman

ACKNOWLEDGMENT

The studies on which these two Reports are based were carried out by the Office of Studies of the Maryland Committee on Medical Care.

The Office of Studies is maintained under a joint agreement of the Maryland State Planning Commission with the Rockefeller Foundation and the Medical and Chirurgical Faculty of Maryland.

Appreciative acknowledgment is made of the patient and efficient cooperation of Drs. Herbert Notkin and Bettie Rogerson of the Bureau of Medical Services, State Department of Health; Dr. Wilfred Davis and Mr. C. A. Rittler of the Medical Care Section, Baltimore City Health Department; the Health Officers of Maryland's twenty-three Counties; the Directors of the six Medical Care Clinics; and many others all over the State who gave valuable assistance.

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A REVIEW OF THE MEDICAL CARE PLAN OF MARYLAND

INTRODUCTION

On March 23, 1951, the State Senate of Maryland, by Resolution No. 22, requested the Governor of Maryland to appoint a Committee to review the program of medical care for the indigent and medically indigent persons in this state.

The Resolution pointed out that six years had elapsed since Maryland had embarked upon a program of medical aid to the indigent and the medically indigent; that the cost of the program had risen fivefold and additional costs could be anticipated. The Senate, therefore, felt it was desirable to undertake to review the effectiveness and the further necessity of the program. This Senate Resolution called on the Governor to appoint a committee of seven persons, not more than three of whom should be representatives of the medical profession, to be known as the Committee to Review the Medical Care Program. Its purpose was to conduct a survey of the efficiency, cost and social implications of this program. The report was to be submitted to the Legislative Council on January 1, 1952.

On August 29, 1951, the Governor wrote to the Director of the State Planning Commission and suggested that its Committee on Medical Care should undertake this study. On September 21, 1951, the Committee on Medical Care accepted the Governor's request to assume responsibility for the study and authorized its Chairman, Dr. Maurice C. Pincoffs to appoint the Committee to Review the Medical Care Program. The Committee was appointed and in early October of 1951, the Governor announced its membership.

It was obvious no report could be ready in the short time remaining, and the State Senate, by Resolution No. 8, passed at the 1952 session extended the time for filing the report to December 1, 1952.

HISTORY OF MEDICAL CARE PLAN

On the initiative of its doctors, Maryland set out to prove that a state can solve its own health problem without Federal aid or Federal intervention. The Maryland Medical Care Plan provides medical care for the indigent in Baltimore City; that is, those who are on the relief rolls; and for the indigent and medically indigent in the counties. The medically indigent are those who are ordinarily self-supporting, but who cannot pay the cost of medical care.

In 1951, 851 physicians, 280 dentists and 357 pharmacists participated in the Program in the counties. The number of prescriptions filled was 113,480. Those receiving this medical care numbered 24,837. The total cost of the Program was $661,126, all paid by the State of Maryland, with no contribution by the Federal Government or the local political subdivisions of the state.

A Program of such wide scope, so important to the health of a state, unfortunately, is not well known throughout Maryland, and all too often misunderstood.

The Medical Care Program in Maryland is in effect in rural areas, suburban areas, large cities and in the metropolitan City of Baltimore. There are two distinct medical care services; the one in the counties, the other in Baltimore City. They are different in some details of their operation, but have one aim in common — medical care for the low income groups.

The origin of the Plan goes back two decades. The Medical and Chirurgical Faculty of Maryland (the State Medical Society, founded in 1799) held a meeting on October 31, 1932, when outstanding physicians of national fame debated the report and recommendations of the National Committee on the Costs of Medical Care.

At a subsequent meeting the late Dr. John M. T. Finney, Sr., a former president of the Medical and Chirurgical Faculty of Maryland, pointed out to his professional colleagues that

if the medical profession itself did not take the leadership in studying the medical care needs of Maryland and in presenting for public adoption a reasonable plan to meet these needs, such action would without doubt be taken by groups outside the medical profession.

A few years later, after a great deal more discussion, Dr. M. C. Pincoffs, Professor of Medicine of the University of Maryland, outlined the defects in the existing medical care program of Maryland and proposed certain remedies. He urged the appointment of a subcommittee of the Maryland State Planning Commission whose responsibility would be to plan for necessary improvements in medical care in Maryland.

On August 23, 1939, the details of the plan proposed by Dr. Pincoffs were embodied in a letter sent by Dr. Victor F. Cullen, acting president of the Medical and Chirurgical Faculty of Maryland to Dr. Abel Wolman, Chairman of the Maryland State Planning Commission.

This letter urged the State Planning Commission to appoint a special standing committee "whose function it shall be to keep under constant survey the problems of medical care for the citizens of this state and to formulate from time to time recommendations for better utilization and for extension of existing medical facilities and for the institution of such new facilities as are required".

Among the seven major deficiencies pointed out, special attention was called to the lack of organization or funds for medical care in their homes for those on relief or without means of paying for their medical care.

As a result of this letter, the Planning Commission set up the Committee on Medical Care and named Dr. Maurice C. Pincoffs as Chairman. The first meeting was held on January 23, 1940.

THE COUNTY MEDICAL CARE PROGRAM

Because of the more pressing need for a program for medical care in the provinces outside of Baltimore City, the State Committee on Medical Care gave its first attention to a survey of the needs in the 23 counties of Maryland. Its report was published on April 15, 1944, and contains the findings and recommendations for a long-term medical care program for the state's indigent and medically indigent.

The report proposed an important and basic extension of the duties of the State Department of Health to include responsibility for a personal health service to the indigent and the medically indigent. Maryland is fortunate, as the report emphasized, in the general high level of medical care received by her citizens and although the medical profession, on a voluntary basis has unselfishly and untiringly given medical care to the poor, nevertheless in some sections of the State, all essential medical services are not available to this segment of the population.

The Committee on Medical Care recommended a program to provide medical care for the indigent and medically indigent in the counties to be established by the State of Maryland and to be administered by the State Department of Health.

The State Department of Public Welfare would have no responsibility for providing medical care but would determine the financial eligibility of the applicants. The report recommended that specific appropriations, adequate to finance the program, should be made by the State of Maryland for payment to physicians, hospitals, dentists; for drugs and for administrative expenses. To implement these recommendations, the State Board of Health was authorized to establish a Council on Medical Care to act in an advisory capacity.

The Committee proposed a separate study of the medical care problem of Baltimore City.

The General Assembly of Maryland, at its session in 1945, enacted into law these recommendations, and the program was soon thereafter put into operation.

The appropriation by the state for the first two years of operation was $200,000 a year.

The administrative organization was then set up and one by one, the counties began to participate in the program, usually beginning with the indigent and then taking up, gradually, the care of the medically indigent. This was logical, as county health departments were not organized to apply a means test to determine eligibility for those who were medically indigent; whereas, the Department of Public Welfare in the counties had already certified those who were on their relief lists. By June of 1948, all 23 counties were participating in the complete program.

Thus, was begun a medical service to those too poor to pay for it. The patient is given complete independence of choice as to his doctor, and the doctor may accept or refuse any individual as a patient.

ORGANIZATION AND ADMINISTRATION

A. State Level

1. Bureau of Medical Services

The Medical Care Act of 1945 provided for a new bureau in the State Department of Health to be known as the "Bureau of Medical Services". This Bureau was created to establish and administer a medical care service for the indigent and medically indigent of the counties and was authorized to enter into contracts with physicians, dentists, hospitals and pharmacists for the care of eligible persons. The law provided for the appointment of a Chief of the Bureau and such other employees including nurses, secretaries, statisticians as might be necessary to administer the Medical Care Program in the counties of the state.

The Program is decentralized; it permits local supervision by non-political people, with the hope as stated in the letter of transmittal of the initial report to the State Planning Commission that the Program "will encourage more effective integration of all the state's medical resources, private, governmental and voluntary, and assure more and better health services to all our citizens". It is limited by the extent of the budget appropriation approved by the Governor and allowed by the Legislature.

Through the county health departments, this Bureau carries out the regulations and policies set up by the State Board of Health for the conduct of the Program. It receives reports from county health departments and statements of charges from physicians, dentists and pharmacists and authorizes payment by the State Treasurer. It records in detail the data from these statements and, at regular intervals, publishes complete statistical information on the operation of the Program.

The Bureau of Medical Services has no direct contact with the participants in the Plan; it administers the Plan at state level only. Supervision over the work in the counties is carried out by contact between members of the Bureau and the county health department, correspondence, visits, regional conferences and semi-annual meetings of county health officers.

The Medical Care Act also made the Bureau of Medical Services responsible for the conduct and operation of such hospitals as may be established by law for the care of persons suffering from chronic diseases. The Bureau is known, therefore, as the "Bureau of Medical Services and Hospitals". Its staff includes a chief, an assistant chief, a superintendent for each of the chronic hospitals, a chief of the Division of Hospital Services, a statistician, and clerical staff to carry out the work of the Bureau.

These other responsibilities take a considerable portion of the staff's time and include other medical care activities, such

as the Hospital Inpatient Program under which the state pays certain hospitals a specified sum per day for the care of individuals certified by county welfare departments; the Hospital Outpatient Program, under which certain people certified may have their care at hospital outpatient departments paid for from a fund set up on a county-state or city-state matching basis. The Bureau also administers the Chronic Hospital Program which now includes one hospital already completed at Deer's Head, near Salisbury; a second, which is being set up at Montebello, in Baltimore City; and the construction of a third, to be built at Hagerstown. Other activities of the Bureau include cancer control, hospital licensing and administration of the Hill-Burton Hospital Construction Program.

2. Council on Medical Care

The Act made provision for a Council on Medical Care whose 13 members represent the several professional and official interests most directly affected by the Program. These include the medical, hospital, dental, nursing and pharmaceutical professions, the two medical schools, the State Board of Health, the Department of Public Welfare, the Department of Mental Hygiene, and members from the Medical and Chirurgical Faculty and from the Maryland Medical Association.

The Council advises on the formulation of policies for the administration of the Program. Its recommendations on policy or procedure must be approved by the State Board of Health before they become effective. It has no authority to make or enforce regulations.

At the beginning of the Program, the Council helped to establish forms of contracts, scales of fees, eligibility criteria, and administrative procedures.

The program of medical care is intended to be a joint cooperative effort of the State Health Department and the in-

terested professional groups in Maryland. One of the most important functions of the Health Department and the Council is to maintain working relationships with the organizations of physicians, dentists and pharmacists in developing new plans, or settling questions regarding the use or abuse of the Program anywhere in the state.

The Council meets nine or ten times a year to hear and discuss the Bureau's operational reports, to consider administrative problems relating to policy and procedure, to prepare budgets, and to make recommendations to the State Board of Health for changes in regulations.

3. Fees

The Council on Medical Care set up a single scale of fees for the whole state under the Program. Basic fees for physicians are $2.00 for an office visit and $3.00 for a house call during the day, with additional small fees for night calls and for mileage. These fees have remained unchanged since they were established in 1945. At that time they conformed fairly closely to charges made to private patients. In a few localities this is still true, but in most areas throughout the state, physicians' fees for private patients are higher and in some places double the scale paid by the state under the Program. He is not paid for visits to patients in hospitals or nursing homes.

The physician, in addition to his set charges for home and office calls, is also paid for obstetrical service in the home or hospital, for minor surgery in the office, for dispensing drugs, for laboratory tests and X-rays.

The scale of fees also established for authorized dental services has remained unchanged and today is appreciably lower than charges made to private patients.

Where a physician dispenses his own drugs, he is allowed to make a charge for them. If the drugs are supplied through

a prescription furnished by the physician and filled by the pharmacy, the Program allows payment for the wholesale cost of the ingredients, plus the cost of container, plus a mark-up to the pharmacist (Appendix B).

B. County Level

1. County Health Departments

The County Medical Care Program is administered by the local health department in each of the 23 counties under the direction of the county health officer.

In a few of the smaller counties the secretary of the health department does most of the work connected with interviews and records. Most counties have one or more clerks who devote full-time to the Program. One county has a full-time supervisor, trained in medical social service and in two other counties the staff medical social worker devotes a considerable portion of her time to medical care cases.

The medical care activities of the public health nurse vary considerably from county to county. As a general rule, she is interested in the Program insofar as it provides care for the families she has under her supervision. In most counties she is second in importance to the physician in making the Program known to needy families. In twenty counties she makes a home visit and investigates those applicants who are unable to come to the health department, and in 2 counties there is a well developed Program of bedside care.

2. Certification and Determination of Eligibility

The county health department issues certificates for all recipients of medical care, both indigent and medically indigent. The eligibility of the indigent is determined by the County Board of Welfare, which sends a notice to the health department and a certificate is automatically issued. The determination of eligibility for the medically indigent is a function of the health department.

An applicant for certification as a medically indigent comes to know about the Program from his family physician, from the public health nurse, the public welfare department or neighbors. He must procure an application form which is filled in and which, in 18 counties, must carry the physician's signature, his diagnosis and his estimate of the duration of treatment necessary. In 15 counties applicants are required to come to the health department for the interview, unless physically unable to travel. In 7 counties applications may be accepted by mail, if the supporting papers are in order.

As a general rule, applicants are interviewed by a clerk or secretary whose chief duties are in connection with the administration of the Medical Care Program. In only one county does the health officer assume responsibility for interviewing every applicant. In all but the larger counties where the caseload is heavy, the health officer reviews the application before approving certification, and in those cases which are borderline with regard to the means test, he makes the final decision.

In determining eligibility various sources of information are tapped. In small counties the public health nurses have a valuable fund of information about almost everybody who lives in the county. One of the best sources of reliable advice regarding need and worthiness is the general medical practitioner. It is rare that a certificate is granted where the family physician feels that the applicant is ineligible.

Certificates for medically indigents may be issued for any period from one day up to six months. Usually, they are good for less than six months. They are frequently given for one or two visits to the physician or dentist. As a general rule, individuals are not certified as medically indigent in advance of need of medical care. There are occasional exceptions for elderly people. Whole families are certified in one county frequently, in 7 rarely; and in one, families are certified in advance of need. In most counties it is a general practice to certify each individual as and when the actual need arises.

When the patient has been certified, he is free to go to the physician of his choice for the medical care he needs. The physician is free to accept him or not.

In the Health Department a file is opened for each person who makes application. This file is a permanent record and on it are noted all certifications and bills for services which the Program has made it possible for him to obtain.

The physician has a record form for every medical care patient who consults him. On this form he keeps a record of the services rendered during any one month. At the end of the month the completed form is sent to the Health Department, where data are transferred to the patient's permanent record, and the form is checked for errors before approval and transmission to the Bureau of Medical Services for payment.

A similar procedure is followed for dental services. Copies of all prescriptions filled for medical care patients are forwarded through the Health Department to the Bureau. The tabulation and reporting of the statistical data collected from the monthly bills is done by the Bureau, which sends to the health officer in the county each month a report showing the total expenditures with details of the service rendered by each physician to each patient he treated.

With the exception of the few counties in which public health nurses visit medical care patients, the Health Department has little contact with the recipients of the service. As a matter of fact, it may only see them when they come up for certification and knows little about the progress of any particular case, except for the information which is available from the monthly statements.

In a few county health departments which have always carried out a program of clinics for pre-natals, infants, venereal diseases, immunizations, etc., certain limited services are available to the medical care patients.

3. County Advisory Committee

The basic fundamentals of policy are all determined at the state level. The State Council on Medical Care has felt that there should be a decentralization of the Program; that is, a local body to appraise the needs, to suggest services most urgent and to interpret the general policies in its area. Accordingly, county advisory committees were set up to bring the administration of the state Program to the county level.

The membership of the county advisory committee includes representatives from the county medical society, dentists, the executive of the county welfare board, one member of the Board of County Commissioners, the county health officer, and any others whom the committee might wish to add. The chief value of these county advisory committees is an educational one, to keep the members in close contact with the Program and to have them share a sense of responsibility for its administration.

Committees may discuss eligibility of individual cases or extent of the services but the solution of local problems must be within the framework of the general rules and regulations laid down by the State Board of Health. The local group cannot change statewide eligibility scales or means tests to conform to local opinion.

Today, advisory committees are active in only seven counties. Of these, three meet quarterly; two meet annually, and of the two which meet when called, one is incomplete in membership, being made up of professionals only.

4. County Department of Welfare

Certification for medical care is the joint responsibility of the health department and welfare department. The welfare department determines eligibility for public assistance for the indigent. When a family is on the relief rolls, it is entitled to medical care under the Program as provided by law. The health department must issue a certificate, when requested, to all recipients of relief.

OPERATION OF PROGRAM

Senate Resolution 22 refers specifically to the cost of the Medical Care Program. It states that annual expenditures have increased fivefold since the first year of the service, and that they show indications of going still higher.

A. Statistical Highlights

In the following pages a summary of statistical highlights is presented showing the growth of the Program over the past five years (1947-1951). It is followed by more detailed information on the operation for 1951 (Appendix C).

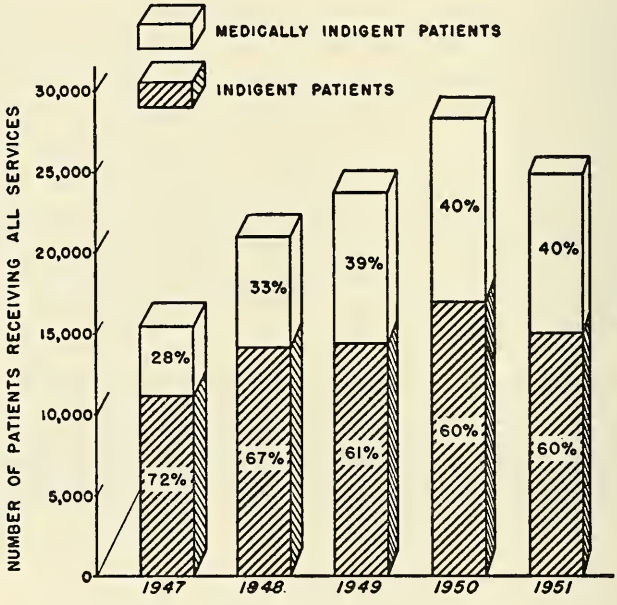
Although the Medical Care Act became effective on July 1, 1945, at least three years were required for the period of development. Organization, county by county, first for the indigent and then for the medically indigent, was slow. It was March, 1946, before the Program had been set up in all counties for the indigent and June, 1948, for the medically indigent. The addition of new counties and certifying of backlogs of indigent caused rapid rises in county and total caseloads those first years. These marked annual increases did not cease until 1948.

Since 1948 marks the end of the initial period of development and the first year in which the Program was operating in all counties, 1948 medical care caseloads and costs are used as a basis for comparison with those of subsequent years.

Chart No. 1 shows the number of patients receiving medical care annually for the five-year period. The greatest number treated in any one year was in 1950, with a total of 28,260. In 1951, there was a drop to 24,837. The total number of patients treated in 1951 was 18% more than in 1948. In 1948, 66% of all patients were indigent. In 1951, 60% were indigent.

CHART No.1

GROWTH OF COUNTY MEDICAL CARE PROGRAM 1947 — 1951



PATIENTS RECEIVING SERVICE

	1947	1948	1949	1950	1951
TOTAL NUMBER OF PATIENTS	15,414	21,051	23,695	28,260	24,837
NUMBER OF INDIGENT PATIENTS	11,161	14,115	14,386	16,912	15,022
NUMBER OF MEDICALLY INDIGENT PATIENTS	4,253	6,936	9,309	11,348	9,815
PERCENT OF PATIENTS MEDICALLY INDIGENT	28%	33%	39%	40%	40%

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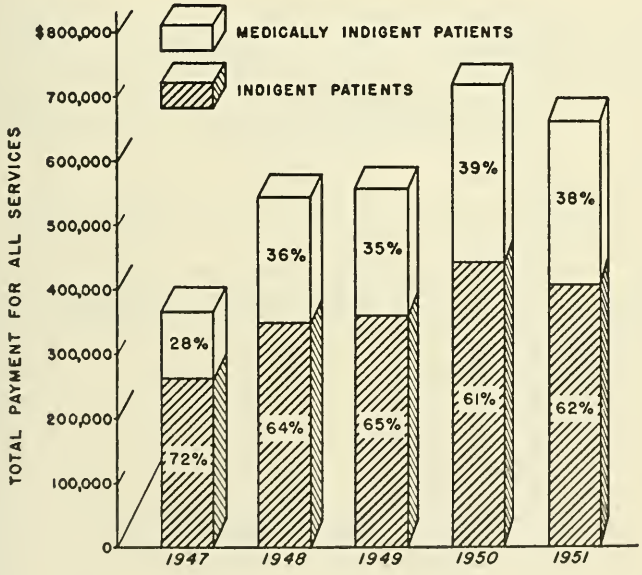
Chart No. 2 illustrates the annual expenditures of the Medical Care Program, 1947-1951. These are totals of medical, dental, drug and diagnostic costs and do not include administration. For the period under consideration, 1950 was the peak year with the total expenditure of $718,083. Expenditures for 1951 were 22% higher than for 1948.

CHART No.2

GROWTH OF COUNTY MEDICAL CARE PROGRAM 1947 — 1951



EXPENDITURES

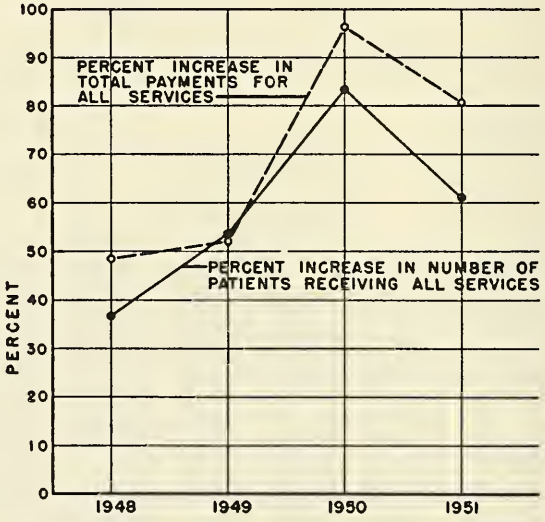
	1947	1948	1949	1950	1951
ALL SERVICES	$366,184	$543,343	$556,863	$718,083	$661,126
FOR INDIGENT PATIENTS	263,286	348,795	359,501	440,924	408,677
FOR MEDICALLY INDIGENT PATIENTS	102,898	194,548	197,362	277,159	252,449
PERCENT FOR MEDICALLY INDIGENT PATIENTS	28%	36%	35%	39%	38%

MARYLAND STATE PLANNING COMMISSION

Chart No. 3 shows that the increase in cost for all the medical services (1947-1951) bears a close relationship to the increase in the number of patients treated. However, the increase in total expenditures cannot be wholly explained by this one factor. In 1947, the cost per patient for all medical services was $23.76. In 1951, the cost was $26.62.

CHART No. 3

PERCENT INCREASE IN TOTAL PAYMENTS FOR, AND NUMBER OF PATIENTS RECEIVING, ALL SERVICES



1947 figures for payments and patients used as a base

	PERCENT INCREASE			
	1948	1949	1950	1951
PATIENTS TREATED	36.6	53.7	83.3	61.1
COST FOR ALL SERVICES	48.4	52.1	96.1	80.5

MARYLAND STATE PLANNING COMMISSION

An analysis of expenditures and volume of physicians' and pharmacists' services shows the following: a) the average payment per patient for physicians' services showed no appreciable difference during the five years; b) the average payment per prescription rose steadily during the five-year period from $1.19 to $1.50; c) in 1947, physicians wrote 45 prescriptions per 100 physicians' calls; in 1951, the ratio was 66 per 100 calls, or an increase of 47%. The increase in cost for all services per patient treated is apparently largely attributable to rising expenditures for drugs during this period.

Chart No. 4 illustrates how the dollar spent for medical services was distributed by the type of service rendered in 1947 and in 1951.

In Table No. 1, the 24,837 patients treated in 1951 are grouped according to the cost of their treatment. Seventy-four percent of the patients cost under $30 each to treat; 45% cost less than $10 and 27% cost less than $5.

TABLE 1

NUMBER OF PATIENTS RECEIVING SERVICE BY COST GROUP: MARYLAND COUNTY MEDICAL CARE PROGRAM, 1951

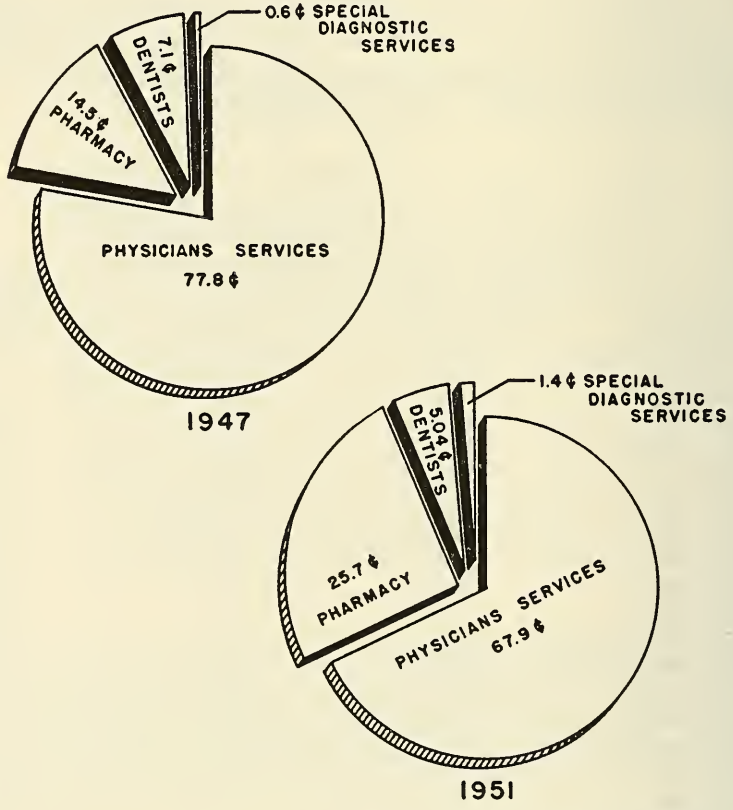
Cost Group in Dollars	*Number of Patients*	*Percent of Patients*	*Cumulative Percent of Patients*
Total	24,837	100.0%	
Under $5	6,809	27.4	27.4
$5 — 9	4,411	17.8	45.2
10 — 29	7,111	28.6	73.8
30 — 49	2,833	11.4	85.2
50 — 69	1,300	5.2	90.4
70 — 89	808	3.3	93.7
90 — 109	499	2.0	95.7
110 — 129	296	1.2	96.9
130 — 149	234	1.0	97.9
150 — 199	279	1.1	99.0
200 — 299	202	0.8	99.8
300 — 399	35	0.1	99.9
400 — 499	12	*	99.9
500 — 599	5	*	99.9
600 — 699	—	—	99.9
700 — 799	3	*	100.0

* Less than 0.1%.

The number of patients receiving medical services in 1951 varies considerably in the counties of Maryland, from 168 in Kent, to 4,151 in Baltimore County. The range of total payments for these medical services in the 23 counties was from $4,079 to $94,403. It is obvious that these variations are, in the main, due to the differences in population in the various

CHART No. 4

DISTRIBUTION OF THE DOLLAR SPENT FOR ALL SERVICES BY TYPE OF SERVICE RENDERED 1947 AND 1951



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counties. This, however, is not the sole explanation, as is shown in Chart No. 5 which illustrates the proportion of the total population of each county which received medical care in 1951. Garrett County's rate, which was fourteen times that of Prince George's County, may be explained by economic differences between the two counties. This explanation, however, does not hold for some of the intermediate counties.

CHART No.5

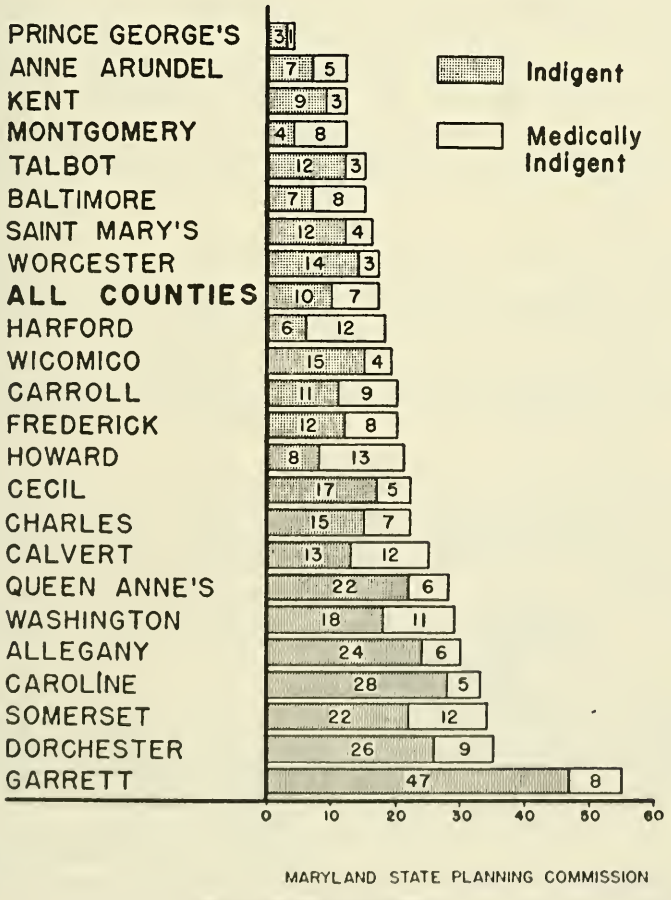
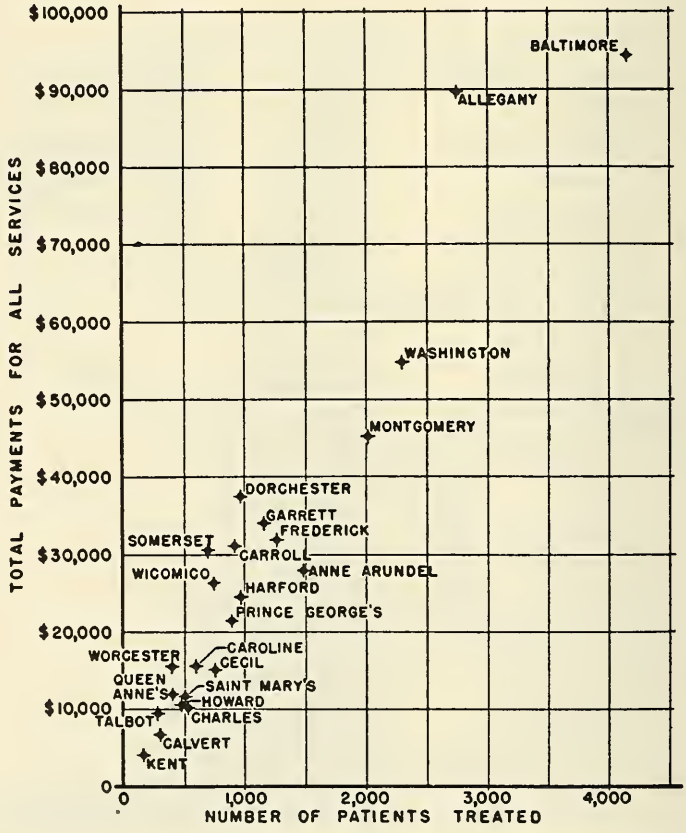


Chart No. 6 in which the number of patients receiving services and the total payments for all services for each county are plotted, shows that there is a definite correlation between the patient load and the total expenditures for the counties. However, certain exceptions to this rule are noted. For example, Wicomico with 746 patients and Cecil, with 762

CHART No. 6

TOTAL PAYMENTS FOR ALL SERVICES AND TOTAL PATIENTS TREATED IN EACH COUNTY — 1951



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patients treated, have greatly divergent expenditures. The Program in Somerset cost $30,607; and Anne Arundel, $28,000 in 1951 — practically the same expenditure. Anne Arundel, however, treated slightly more than twice the number of patients as Somerset. Other examples of these differences are Allegany and Baltimore Counties, and Prince George's and Carroll.

Each of the above pairings has been analyzed with regard to cost per patient for physicians' services and cost per patient for pharmacy services. These two services, together, account for more than 94% of the total payments. In Anne Arundel County, the average cost per patient for physicians' services is the lowest of any county in the state. Somerset, on the other hand, is very much above the average for all counties. The average number of physicians' visits per patient is the lowest in the state in Anne Arundel and the highest in the state in Somerset. If we compare the average payment per patient for pharmacy services, we find that Somerset is, again, the highest in the state; whereas, Anne Arundel is below the county average.

Although Prince George's and Carroll Counties treated approximately the same number of patients in 1951, there was considerable difference in expenditures. It cost more to treat a patient in Carroll County because the Carroll physicians made more visits per patient than did those of Prince George's.

It is perfectly obvious that the volume of caseload depends largely upon local economic conditions. That it is not the sole factor is illustrated by the differences in medical care rates between Prince George's and Montgomery Counties, adjacent to each other and with many similar characteristics.

The range of cost in all 23 counties is interesting. For example, the cost for *all* services per patient range from $18.83 to $44.17; the cost of physicians' services varied from $14.69 in the lowest county to $32.30 in the highest county, with an average for the state of $20.97 per patient treated.

It appears, also, that there is a wide variation in the amount spent for drugs per patient. It might be noted, however, that the highest per patient expenditure for drugs was $20.81, whereas, the next lowest was $16.74 or some $4.00 less. The average number of physicians' visits varied from 5.9 per patient to 11.3, and the percentage of house visits to total visits showed a range of 14.6% to 61.7%.

B. Diagnoses

A survey of physicians' reports for 1951 made by the Bureau of Medical Services showed that 24% of the reports and 26% of the payments were for patients suffering with circulatory diseases; 22% of the reports and 18% of the payments went for treatment of respiratory diseases. The next group, in order of frequency, is that of allergic, endocrine, metabolic and nutritional diseases — which comprised 8% of the reports and 8% of payments. No other diagnostic group represents more than 6.5% of the total.

C. Professional Participation

TABLE 2

Number of Participating Professional Personnel by Location of Professional Office; Maryland County Medical Care Program, 1951

Location of Office of Professional Participant	Number of Participating		
	Physicians	*Dentists*	*Pharmacies*
Total—All Professional Participants...	851	280	357
Baltimore City	111	48	86
Other States and D. C.....	90	16	35
Counties of Maryland.....	650	216	236
Estimated No. of Active Professional Personnel in Counties.....	894	371	267
% in Counties Participating.....	72.7%	58.2%	88.4%

1. Physicians' Services

In 1951, 86% of patients served received physicians' services; 68% of the cost of the Program went to pay for these services. Of the $448,780 paid to physicians, 90% was for visits; 70% of which were office visits and only slightly more than 2% were house visits made at night. The table below gives the details of payments to physicians by types of service.

TABLE 3

PAYMENTS TO PHYSICIANS BY TYPE OF SERVICE; MARYLAND COUNTY MEDICAL CARE PROGRAM, 1951

Type of Physician's Service	*Payments to Physicians*	*% of Total*
All Physicians' Services	$448,779.00	100.0%
Calls	404,179.00	90.1
Obstetrical Service	14,545.00	3.2
Laboratory and X-Ray Service	4,084.00	0.9
Consultant Service	2,480.00	0.6
Minor Surgery & Miscellaneous	2,335.00	0.5
Dispensed Drugs	11,745.00	2.6
Travel	5,724.00	1.3
Additional Patients	3,686.00	0.8

In 1951, the physicians averaged 8.1 visit per patient. In 1947, the figure was 7.1. The number and type of visits varies with the age of the patient. With increasing age, more calls are necessary and of these calls a greater proportion are house visits.

The Annual Report also shows that the average payment for physicians services per patient for the age group 5-14 was $8.77. This figure increased with advancing age and at 65 and over, was $31.00.

TABLE 4

NUMBER OF PARTICIPATING PHYSICIANS AND PAYMENTS TO PHYSICIANS BY PAYMENT GROUP; MARYLAND COUNTY MEDICAL CARE PROGRAM, 1951

PAYMENT GROUP IN DOLLARS	PARTICIPATING PHYSICIANS		
	Number	*Percent Of All Physicians*	*Cumulative Percent Of All Physicians*
Total	851	100.0%	
Under $ 100	362	42.5	42.5
$ 100 — 499	226	26.6	69.1
500 — 999	120	14.1	83.2
1000 — 1999	95	11.2	94.4
2000 — 2999	29	3.4	97.8
3000 — 3999	6	0.7	98.5
4000 — 4999	9	1.1	99.6
5000 — 5999	2	0.2	99.8
6000 — 6999	1	0.1	99.9
8000 — 8999	1	0.1	100.0

The above table illustrates the distribution of the Medical Care Program among the 851 participating physicians, according to income. In 1951, 588 of these, or 69.1% received less than $500 each. Although 19 physicians received more than $3,000 for 1951 from the Program, 81% of all money paid to physicians went to those who received less than $3,000 from the Program for their work.

2. Dental Services

Fourteen percent of patients and only 5% of all payments in 1951 went for dental care. The reason for this is the scarcity of dentists in both the rural and urban areas who will accept medical care patients. Especially where children are concerned, this Program is of great importance. However, in every county there is an insufficient amount of available dental service and the public health personnel has great difficulty in obtaining dental care for the indigent and medically indigent. The lack of facilities for negroes is also a serious problem, even in the counties bordering on the large metropolitan areas. The table below, gives in detail, the expenditures made during 1951 for dental services.

TABLE 5

PAYMENTS TO DENTISTS BY TYPE OF SERVICE: MARYLAND COUNTY MEDICAL CARE PROGRAM, 1951

Type Of Service	*Payments To Dentists*	*Percent Of Total*
All Services	$33,230	100.0%
Fillings	10,555	31.8
Extractions	9,979	30.0
Denture Service*	8,745	26.3
X-rays	1,915	5.8
Fluoride Treatments	527	1.6
Other Services**	1,509	4.5

* Includes full and partial plates and denture repairs.

** Includes prophylaxis, anaesthesia, services with exceptional fees and peridental treatments.

3. Pharmacy Services

With the exception of highly experimental drugs, the list which may be prescribed by physicians or dentists to medical care patients is almost unlimited. Certain drugs on the restricted list can be prescribed with special permission from the health officer. These prescriptions are filled by licensed pharmacists under a markup fee which is uniform throughout the state. Certain medical supplies are also allowed. These represent about 2% of expenditures for drugs.

In 1951, 113,480 prescriptions were written for 14,551 patients. The average cost of these prescriptions was $1.50. For each 100 physicians' visits 66 prescriptions were written. Twenty-nine percent of the pharmacy expenditures represent markup. The remainder represents ingredients and containers.

Eighty-eight percent of prescriptions filled were uncompounded. There is an increasing tendency throughout the country for the physician to write fewer and fewer prescriptions which require compounding.

In 1951, 236 pharmacies in the counties and 121 in Baltimore City and outside of the state, participated in the Program. The income of these 357 pharmacists is given in the table below. Seventy-four percent of all pharmacists participating took in less than $500 for 1951 from the Program.

TABLE 6

PAYMENTS TO PARTICIPATING PHARMACISTS; MARYLAND COUNTY MEDICAL CARE PROGRAM, 1951

PAYMENT GROUP IN DOLLARS	PARTICIPATING PHARMACIES		
	Number	*Percent Of All Pharmacies*	*Cumulative Percent Of All Pharmacies*
Total	357	100.0%	
Under $ 100	169	47.3	47.3
$ 100 — 499	96	26.9	74.2
500 — 999	35	9.8	84.0
1,000 — 1,999	38	10.6	94.6
2,000 — 2,999	9	2.5	97.1
3,000 — 3,999	6	1.7	98.8
4,000 — 4,999	2	.6	99.4
6,000 — 7,999	2	.6	100.0

D. Administration

The Bureau of Medical Services in 1951 spent $162,741 for administration. The County Medical Care Plan is one of the seven programs for which the Bureau is responsible. The number and variety of activities all related to medical care make it difficult to allocate overhead to any one program. An objective analysis, however, estimates the cost of administering the County Program for 1951 at $71,760, or 10% of the $708,845 total. This compares favorably with Blue Shield, which, on a nationwide basis in 1945 spent 12.5% on administration.

The present organization of the Bureau of Medical Services is such that it could care for a considerable increase in the number of patients without the necessity of additional staff (Appendix D).

DISCUSSION

A. Social Implications

Before the Medical Care Program went into effect in Maryland, medical care for those unable to afford it was unsatisfactory and inadequate. It was uncertain, uneconomic, and unfair to the doctor and the patient.

Today, Maryland has a program of medical care that provides service of physicians, dentists and pharmacists to the indigent sick in the Counties of Maryland. It is on a fee-for-service basis paid by the state. There is no reason why poverty should be an obstacle to medical care.

The independent practicing physician is the cornerstone of the American system of private medical practice. The Medical Care Program is founded on the independent general practitioner.

Under the Program the patient has freedom of choice of his physician. The doctor, likewise, has freedom of choice. He may accept or reject the patient, as he desires.

The State of Maryland pioneered in embarking upon the Program. The State of Washington and Hawaii have fol-

lowed the lead with similar programs adapted to their local conditions.

To abolish the Medical Care Program or to cripple its effectiveness by drastic cuts in budget appropriations would be unthinkable. It would create a chaotic state of affairs that would leave the poor sick in many areas without any medical care. In one county two doctors who receive substantial portions of their income from this payment of care for the poor would have to leave the rural area they now serve, and there would be no doctor either for the poor or for those able to pay. There simply would be no medical care in that region.

The aged and the chronically ill have a sense of security given them by possession of their medical care card. It means they can call for the services of a doctor when illness comes. The doctor, who has spent years of his life acquiring his medical education and thousands of dollars paying for it, will be paid a modest sum for the service he renders to them.

Many persons on relief, because of illness in the family, may now become well enough to earn a livelihood as a result of medical care provided by the Program, and as a result, be taken off the relief loads. Children who might become chronically ill and in later life become permanent public charges are given early treatment under the Program. The good results from the preventive point of view are incalculable.

Proper medical attention early in illness lessens the severity and duration of various diseases and reduces the cost of treatment. One of the economic advantages of the Program is that by making early treatment available to those unable to pay, the necessity of more expensive care in a hospital is often avoided.

The State Department of Health estimates that 73% of all active physicians participate in the Program. If only the general practitioner is considered, the figure would be much higher, nearly 95%. A number of these participating physicians in different parts of the state have been interviewed

regarding their opinion of the Program. Many are critical of certain phases of administration, but almost without exception, the medical profession is strongly in favor of the Program.

Some doctors are critical of eligibility standards. Some object to the small fees and complain that they are not paid for their services to hospitalized cases. None of those interviewed thought that abuse on the part of recipients, doctors, dentists or pharmacists was sufficient to warrant more than censure of the offenders. Not one was in favor of dropping the Program. Several of the leading men in general practice feel that the preventive aspects of the Plan represent a great saving to the state.

Various county medical societies and the Medical and Chirurgical Faculty (at its last meeting in Ocean City on September 12, 1952) have passed resolutions supporting the Program and requesting the Legislature to continue the appropriation of sufficient funds to provide for its proper administration.

In order to determine what the general public knows and thinks of the Medical Care Program, ten community surveys were made in various parts of the state. The interviewers saw and talked with welfare directors, public health nurses, leading citizens, officials of civic clubs, office holders and clergymen.

In these communities there is considerable ignorance as to the existence and operation of the Medical Care Program, particularly among the people of the upper economic classes who do not participate in it. It is only well known among those who are recipients, the physicians, the health department and public welfare staffs. Even in those counties where the advisory committee is active, the function of interpreting the Program to the general public has not been carried out. This is probably due to the fact that most of the health officers are cautious about making the Program known to the general public. They are afraid that if all eligibles learn about the

Program and make application, there is no telling what the cost may be.

Among those interviewed, there was general agreement that the state should take care of its citizens who, through infirmity, old age, or lack of funds are unable to pay their medical bills. They should have competent medical attention, and the medical profession should be paid for its services.

Others were sceptical and, though they had little knowledge of the Program, were convinced that abuse was inevitable. Several cited instances of drunkards or good-for-nothings who are chronic public charges and who should be made to support themselves. Criticism is directed chiefly toward the welfare department whose work is still looked upon with considerable misgiving by some who wonder why people should be on relief under present economic conditions. Many of these same critics, however, knew of families who have received medical care, which they considered well deserved.

There was some evidence of general antagonism on the part of certain well-to-do citizens toward those on relief. The ordinary citizen has a very slight knowledge of what the Medical Care Program is. He thinks that illness means one or two visits to the physician, which anybody should be able to finance. He has never thought out the cost of chronic illness requiring months of treatment, unless he has had an experience in his own family.

Almost without exception, health department personnel favor the Program. They do have certain reservations regarding its administration and policies, but they all feel that the efficiency of their public health work has been greatly enhanced since the Plan went into effect. Those who have been in county health work for a number of years draw a very happy comparison of what they have today, with the lack of facilities prior to 1945.

The county welfare department in almost every instance has a strong feeling regarding the benefits of the Medical

Care Plan. Frequently, illness is the primary factor in bringing a family to the welfare department for assistance. A number of those who are on relief are unemployable because of health conditions. In the upper age group, clients are more likely to be ill and to need medical care. Prior to 1945, the problem of obtaining medical care for people on relief was a very serious one. Various schemes were tried out but none worked satisfactorily and many people suffered for lack of medical care.

In Garrett County where relief loads are the heaviest in the state the Director of Public Welfare has said that before the Plan went into effect there were people who died for lack of medical attention. Since 1945, however, the picture has changed considerably and medical care is now available to all, in spite of the distances which must be traversed at times by patient and physician. There are now two physicians in remote villages who would not be there if it were not for the income which they derive from the Medical Care Program.

It is undoubtedly true that in any Program of this sort, education plays a very important part. The people of Maryland are faced with a problem of medical care for a certain portion of the population which does not have the means to pay for it. The state has adopted a regulation, set up the machinery and made funds available to take care of this problem. The state, however, cannot do this alone, but must depend upon the cooperation of all participants in the Program and the general public to reach a satisfactory solution. Education by the State Department of Health toward this goal has been inadequate and has not been sufficiently stressed in the scheme of administration.

Educational efforts should be at the county level and chiefly under the direction of the county health department. The educational program should be of sufficient scope to include clients, health department workers, physicians, dentists, pharmacists and all concerned with the operation of the Medical Care Plan. It should instruct as to possibilities and

limitations of the Plan and responsibilities of the participants. It is very doubtful that directive circulars and mimeographed communications sent out by the State Department of Health have much effect.

In spite of the fact that there is, at times, considerable discussion regarding new administrative procedures, little attempt has been made to work out a plan for putting suggested improvements into practice on an experimental basis. There are some county health officers who would welcome the opportunity to make studies of this sort.

In only a few counties does it appear that the Medical Care Program has been thoroughly integrated into the general health program. Some health officers state that while this is their ultimate aim, it is a slow process to bring about integration. Some of them feel that this is a radical departure from the original idea in the formation of the State Health Department. Therefore, these new added duties and responsibilities are being carried out without great enthusiasm. Others realize that the problem of medical care, and particularly its relationship to chronic disability, is increasingly important.

B. Cost

The State Legislature, which makes the funds available, and the State Department of Health, which administers their spending, are both anxious to keep expenditures as low as possible and to reduce costs — whenever it is feasible. Various methods have been tried out and a few suggestions have been made as to how these costs might be reduced and to make the existing funds stretch far enough to cover all the needs.

The appropriation for medical care for the fiscal year, 1952-53 was cut $50,000 below the amount requested by the Governor, which was already less than the State Health Department's original request. This cut was made without proper and thorough investigation of the facts and the needs for the coming year, and over the strong protest of the State Health Department.

The Health Department has been given the task of administering the Medical Care Plan. It has been authorized to set up regulations regarding who shall receive this medical care and how these individuals are to be selected. It has been authorized to pay bills based on established fees for services. If the administration of the Program is efficient, money enough for all of its needs should be provided. Cutting the appropriation will not eliminate inefficiency.

In 1950, the cost of operating the Program exceeded the appropriation. In order to continue throughout the year, making the Program available to all who needed it, it was decided to pay less per service. Bills for physicians, dentists and diagnostic services were prorated and paid on the basis of 70% for the last quarter of the year. Although for the most part, proration was accepted graciously, some physicians and dentists made a justifiable complaint. This procedure constituted a breach of contract between the state and the professionals.

It has been suggested that recipients would have a higher sense of responsibility and might tend to use the Program less, if they paid part of their fees. There are various schemes suggested, some of which are similar to the deductible clause used in automobile collision insurance, whereby the patient would pay the first $1.00 or $5.00 of his physician's services, or a nominal fee for each visit to the physician. The county health departments feel, however, that this would not be practical, as it would entail a considerable amount of extra bookkeeping which would not be compensated for by the saving. With regard to the payment for prescriptions, it has also been suggested that a nominal fee be paid by the clients for each prescription. This might be 25¢ or 50¢.

Another suggestion is that the recipient, particularly the medically indigent, be kept informed as to what his treatment is costing and be made to understand that this is a loan from the state or county and one which should be repaid in full, at such time as the individual is financially able.

Based on the assumption that a considerable portion of the medically indigent are undeserving, a suggestion has been made that the counties should contribute to the cost of the Program on a matching basis. This would create an interest in the Program on the part of boards of county commissioners resulting in more careful scrutiny of applications. The survey has shown that only two or three boards of county commissioners take any interest whatever in the Program.

It is impossible to theorize on the advantages or disadvantages or possibilities of any of the above systems. The question of preservation of morale or restoration of morale of these patients, particularly the indigent, is one which is sometimes discussed, but about which very little is being done. In the interest of preserving efficiency of the Program and at the same time keeping costs at a minimum, there must be a ceaseless effort to bring about improvement. No reasonable idea should be abandoned as too theoretical without full discussion, and if feasible, it should be given a fair trial in the field.

The drug bill for the Medical Care Program has increased steadily since 1947. The problem of the cost of drugs is one which besets every administrator of a medical care program in this country and abroad. There are various explanations, all of which are applicable:

"The cost of drugs has risen in accord with a rise in price of all other commodities."

"Dr. Blank prescribes for his medical care patients just as he does for his private patients."

"Physicians don't write prescriptions anymore; they write labels."

"Proprietary preparations are less trouble to the physician and the pharmacist and cost more."

"The younger generation of physicians does not know how to write prescriptions."

"The visits of detail men are responsible for the prescribing of more expensive proprietary preparations."

"I provide the medical care patients with the best available drugs, in order to get them off of medical care as soon as possible, and thus save the state money."

Each of these reasons has been advanced by physicians in different parts of the state. In questioning these physicians, each of whom was a participant in the Program, as to what should be done to reduce the cost of drugs, there has been a very general feeling that the State Department of Health should set up a list of drugs, or a formulary and make suggestions as to what may be prescribed. Some few physicians think that this might lead to dictation on the part of the state and interference with the liberal practice of medicine. But, for the most part, the opinion is that the State Health Department should make some suggestion for the physicians to follow.

Future costs are not predictable. The maximum caseload was reached in 1950. 1951 was lower and 1952 promises to be no higher than 1951. It appears that a leveling off is taking place. This may be due to a general improvement in the method of determining eligibility. If the national economic situation remains unchanged, there should be no great annual fluctuation in costs. In the face of a general depression the medical care caseload would undoubtedly follow closely the numbers of people receiving public assistance (Appendix E).

C. Efficiency

The administration of the Program has been, for the most part, efficient. The survey, however, has found that there is a wide variation in its operation among the 23 counties. There is a lack of standardization of the procedure for determining eligibility, considerable difference in the cost of drugs from one county to the next, and a wide range in caseloads and the cost and quantity of physicians' services.

There can be no rigid yardsticks by which to determine eligibility, even with the income limitation. It has happened that over-income individuals have been given certificates,

but in every instance it appears that circumstances were of an extenuating nature. Frequently, the factor of large unpaid medical bills carried considerable weight in granting the certificate.

Local health officers may exercise some latitude in interpreting the policy as it refers to eligibility, but neither they nor the local advisory committee can change the income scale set up by the state. The health officer can develop a more liberal attitude in some cases and may grant a certificate on the basis of the picture of a particular family's whole problem, rather than on the basis of income alone. This means that the policy of administering the Program by the county health departments depends to a great extent upon the personality of the county health officer and his attitude toward the Program.

Those who determine eligibility take their responsibility seriously, and there is an air of competence and efficiency about their work. However, they are, almost without exception, persons with little background of social instruction or training calculated to fit them for this rather difficult task. If their efficiency is to be judged by the fact that generally there has been very little abuse of the Program by the clients, there is also the complaint in some of the counties that people who deserve help are being denied it.

In some county health departments the interview with the applicant for a medically indigent certificate is carried out in a separate room as a private conversation between the interviewer and the applicant. In others, however, the interviewing is done in the public reception room, or even in the hall. Understandably, patients might be unwilling to divulge their troubles, especially their financial difficulties in public surroundings where people are constantly passing to and fro and often listening in.

Whether or not it is wise to certify in advance of need is a matter which should be carefully explored. Some of the health officers gave as their reason for refusal the fact that

they did not want to build up their own rolls and create a demand for the Program in their particular counties. However, in one county where there has been considerable certification in advance of need the per capita caseload is below the average for all counties.

There is a feeling among the majority of health officers that the efficiency of the service would be increased if the services of medical social workers were more generally available.

The variations in caseloads and in cost of treating patients from one county to the next are due primarily to differences in administrative procedures. There is no unanimity of attitude on the part of health officers toward the Medical Care Program. There is a considerable difference in the interpretation of the regulations regarding the means test and some variation in the procedures for determining eligibility. The attitude of the medical profession is also a considerable factor, as is the relationship of the health officer to the local physician and his ability to direct the Program in the way in which he thinks it should go. There are a few health officers who show no great interest or initiative in working out their problems, but on the whole, the majority are conducting a good Program.

It would seem advisable to examine the policy of decentralization and decide if it has been carried too far. A more uniform standardization of procedures might be brought about if there were a more vigorous relationship between the State Health Department and the county health officers.

This survey has made no attempt to assay the quality of medical care which the individual patient receives. This depends on too may factors, the most important of which is the quality of medical care which the individual physician dispenses to his private, as well as his public patients. The physician has free choice of treatment which he may administer to his patients, whether they pay him directly, or the state pays for them.

Unquestionably, the average indigent or medically indigent patient is getting far better care than he had before

the Program went into effect. Certainly, he is able to obtain more care, more and better medication and a feeling of security in knowing that if he should be ill, attention from his own physician will be available to him.

In eight of the counties the health department staff had a feeling that medical care was being denied to some of the people who should have been certified. Chiefly to blame for this condition has been the income scales which are set up as a criterion of eligibility. In many counties these are considered too low. They are, in effect, the Welfare Department's scale for general assistance. Some seem to feel that they can only certify as medically indigent those persons who would be eligibile for general assistance on the welfare, should they apply.

In carrying on this survey, no definite attempt has been made to run down specific cases of abuse or investigate them. County and State Health Department officials know what is going on. Twenty-one of the twenty-three counties report that abuse on the part of the applicants in attempting to obtain a certificate under false pretenses presents no problem. There are occasional attempts at cheating, but these people are usually known for their unworthiness before certification is applied for. Most of those whose job it is to determine eligibility are local residents with a fund of knowledge about the county population.

In general, health officers, clerks and nurses are of the opinion that people apply because they are sick enough to need medical care and do not have the money to pay for it. Most of them come to the health department at the suggestion of their family physician, or the public health nurse. Some hear of the service through neighbors and apply to the health department first, but in most counties the physician's signanature is necessary to secure a certificate. At times, the physician may be wrong with respect to the applicant's resources, but usually, he knows the real situation regarding the applicant.

There seems to be no general tendency to cheat, but there are occasional instances of undeserving individuals or families obtaining certificates. However, stories of abuse are fairly common in certain localities. Efforts to verify such reports usually show that they are due to misunderstanding, distortion of the facts and in some cases, simple maliciousness. The average citizen has little knowledge of the various agencies for public welfare. He confuses general assistance, hospital inpatient programs, unemployment compensation, the Social Security Program and lumps them all under one heading along with medical care. He condemns the Program, because he has heard some undeserving family has been helped. He does not realize that the health department only determines eligibility of the medically indigent — not those on the welfare program. Inadequacy of state laws governing care of dependent children, dependent parents, and cases of illegitimacy forces the welfare programs to provide assistance and medical care to children or parents who should be provided for by their families.

Shopping — going from one physician to another — occurs on a small scale in some counties. It is usually confined to patients with chronic illness who have little else to do except enjoy a session with the physician when they can see him. Shopping means the patient is getting more treatment than he would ordinarily, if he stayed with one doctor. If this practice were widespread, it would increase the cost of the Program, considerably. However, it has been successfully controlled in every place where an attempt has been made. There is no general complaint from the physician that the medical care patients make unusual demands for their services.

There have been instances where physicians have made more visits to patients than would seem to be indicated by the diagnosis and type of treatment usually followed. As a general rule, these cases can be handled locally, but there are a few chronic offenders who have gone on for some time uncorrected. The State Health Department has been hesitant

about taking disciplinary action in cases involving physicians. Although the instances taken all together are not significant, they could be eliminated entirely. The physicians who were interviewed on this survey are of the opinion that stern measures should be taken by the State Health Department and the Medical and Chirurgical Faculty in cases of intentional abuse.

The doctor must understand that the success, the life or death of the Program, directly depends upon him. He must be made to realize that the funds are limited. If he prescribes expensive drugs or makes more than the necessary number of visits, he is using funds unnecessarily and depriving other people of treatment, and may even be jeopardizing the whole Program. One such instance has a way of becoming known throughout the entire county and is multiplied in the retelling. After participants have been given an opportunity to understand, thoroughly, the Program and their responsibilities, there should then be no hesitancy in correcting, with sharp measures, any deviation from correct procedure.

In every scheme or plan calling for a substantial expenditure of public money and dealing with large numbers of people, perfection is never attained. As this is true in all enterprises of every nature, so it is true of the Medical Care Program. Abuse on the part of the patient and the doctor does exist, but it is small — infinitesimally small — when compared with the overall number of persons and expenditures involved.

Whatever may have been the role of the advisory committees in determining general policies at the beginning of the Program, at the present time their function seems to be decidedly limited. Most health officers, particularly those in the small counties, feel that they are unnecessary and the Program can be operated more smoothly without their participation. In the larger counties these committees are active when problems arise concerning the services of physicians, dentists or pharmacists. In these instances, however, only the professional members of the committees take part.

Since policies determining eligibility of the medically indigent are made at the state level, there is little that the lay members of these committees can do except, perhaps, to become well acquainted with the Program in their particular county, and to act as disseminators of information among the general public. This function, however, has not been carried out.

In the other counties, and particularly those where the number of physicians is twenty or less, the health officer usually takes the responsibility of settling professional problems, and the advisory committee does not exist.

In some counties there is a close working relationship between the public welfare department and the county health department. Two health officers feel that the medically indigent should be certified by the welfare department, but the others believe that the medical aspects of individual cases need professional judgment. Health departments have complained that information essential to determination of eligibility is difficult to obtain from boards of welfare. Public assistance and medical care are so closely allied, that cooperation between the two departments is essential to efficiency.

CONCLUSIONS AND RECOMMENDATIONS

The Medical Care Program for the indigent and medically indigent of the counties of Maryland was originated by the Medical and Chirurgical Faculty. It was developed by the Committee on Medical Care of the State Planning Commission; authorized by the General Assembly at its 1945 session, and is administered by the State Department of Health.

The Program provides an essential service in a fairly efficient manner. If the Program were abandoned or seriously curtailed, it would create a chaotic state of affairs in many parts of the state and would throw a heavy economic burden on the doctors who would take care of some charity patients while others would go untreated and uncared for.

Funds provided in the State Budget have not always been adequate. They fell short of needs in 1950. The cut in the 1953 budget should be restored; otherwise, the curtailment of operations is necessary.

Administration at the state level insofar as records, statistics and accounting are concerned, is efficient.

The state administration must be strengthened in its dealings with county health departments; there must be a closer relationship; there is need for strong leadership at the state level. The staff of the Bureau of Medical Services must get into the field more, find out what is going on, meet the local officials frequently and coordinate the activities of state and county departments.

The state should embark on an educational campaign to explain the Program to the general public as well as the professions directly involved. It must also be thoroughly understood by all those who receive or dispense its benefits.

There is no widespread abuse on the part of the doctors, pharmacists, dentists or recipients. But there is some abuse, and there should not be any at all. The instances of abuse are insignificant when compared with the overall Program, but these instances have not been firmly dealt with. The failure to adopt effective measures for correction may lead to greater abuses and real harm to the whole Program. The responsibility rests squarely on the State Health Department and the medical profession.

There should be a standardization of policies and procedures at the county level. Decentralization can be carried too far.

The State Health Department should find out and make public the reasons for the differences in costs as between counties, as well as other differences that may exist. If the reasons are not known, the State Health Department should make its own survey and find out why — and tell the people.

The county advisory committees should be reactivated. They could be useful, but the spark for leadership must come from the Bureau of Medical Care.

The cost of drugs and frequency of prescriptions should immediately receive the attention of the State Health Department and steps taken at once to reduce costs. This will require education as well as action.

There should be closer cooperation between the Welfare Department and the Health Department at the county level. They should work together, harmoniously and cooperatively. This is important and vital, as the indigent list comes from the County Department of Public Welfare.

There has been no abnormal increase in the cost of the Program. 1945, 1946 and 1947, mark the initial period when the Program was going into operation. By March, 1946, all 23 counties were caring for indigents, but it was not until June, 1948, that all counties had made provision for the medically indigent. The greatest number of patients treated in any one year was in 1950 with a total of 28,260. In 1951, there was a drop to 24,837. 1950 was the peak year with the total expenditure of $718,083, which is 32% higher than the cost for 1948. There has been no "fivefold" increase in cost as mentioned in the Senate Resolution when comparable years are considered.

There is no method of determining the future budgetary needs of the Program. They depend, to a great extent, on economic conditions which may vary from county to county and from year to year.

December 5, 1952

Baltimore, Maryland

APPENDIX A

SENATE RESOLUTION
No. 22

SENATORS ADKINS, HYDE AND SYBERT

By the SENATE, March 23, 1951

Introduced, read the first time and adopted
By order, C. ANDREW SHAAB, *Secretary*

Senate Resolution requesting the Governor to appoint a Committee to review the Program of Medical Care for the indigent and medically indigent persons in this State.

WHEREAS, approximately six years have elapsed since this State embarked upon a Program of Medical Aid to the indigent and medically indigent; and

WHEREAS, the cost to the State of Maryland of said Program has increased approximately five-fold in the period of its operation; and

WHEREAS, there is reason to anticipate an additional and further increase in the cost of said Program; and

WHEREAS, it is desirable at this time to undertake to review the effectiveness and further necessity of said Program; now therefore be it

Resolved by the Senate of Maryland, That the Governor of Maryland be and he is hereby requested to appoint a Commission consisting of seven (7) persons, not more than three (3) of whom shall be representative of the Medical Profession; said seven (7) persons to be known as the Committee to Review the Medical Care Program, and be it further

Resolved, That such Committee conduct a study of the efficiency, cost, and social implications of the Program of Medical Care now being conducted by the State of Maryland, and be it further

Resolved, That the Governor be requested to make available to such Committee, such clerical and professional staff as may be necessary; such staff to be paid from funds available to the Governor, and be it further

Resolved, That such Committee shall report its findings and recommendations to the Legislative Council by January 1, 1952.

APPENDIX B

FEE SCHEDULES

For Physicians

Office and Home Visits:

Office Visit	$ 2.00
Home Visit (8 A.M. to 8 P.M.)	3.00
Home Visit (8 P.M. to 8 A.M.)	4.00
Home Visits more than 10 miles from phyisician's office:	
Additional Payment	1.00
When more than one patient is seen in a single home visit:	
For First Patient	2.00
For Each Additional Patient	1.00
Physicians may charge for visits to patients in nursing homes, but not in hospitals or other institutions.	
Home or Hospital Delivery	35.00
Minor Surgery in Office: 50% of Blue Shield Fee	

Consultation:

Specialists	10.00
Non-Specialists (Plus mileage fees)	5.00
A moderate special schedule for X-rays and laboratory examinations.	

Drugs:

The usual physician's fees for home and office visits include payment for simple drugs. If he dispenses drugs costing more than 50¢, he may make the additional charge on his report of service.

For Pharmacists

Payments to pharmacies are made on the basis of the wholesale cost of ingredients, plus the cost of container, plus a markup of 35¢ for uncompounded prescriptions, and a markup of 50¢ for compounded prescriptions, where the wholesale cost of ingredients is less than $2.50.

If the cost of ingredients is $2.50 or more, the markup is a straight 30%.

For Dentists

Extractions:

Single — not to exceed	$ 2.00
Multiple — for same patient at same sitting—	
First tooth	2.00
Each additional tooth	1.00
Maximum payment for one patient at one sitting	10.00

Fillings:

Silver amalgam	$2.00 to 3.00
Silicate, or other cement	2.00

X-rays:

Each X-ray	1.00
Maximum fee for one patient	5.00

Other Office Treatment 2.00

Dentures (vulcanite only):

Upper or Lower — not to exceed	35.00
Upper and Lower — not to exceed	60.00
Repair of Denture — not to exceed	6.00

Oral Surgery:

Same basis as physicians.

Home Visits (when essential):

Same basis as physicians.

APPENDIX C

HIGHLIGHTS OF MARYLAND COUNTY MEDICAL CARE PROGRAM
1947 — 1951

Index of Service and Related Data	Calendar Year				
	1947	1948	1949	1950*	1951
Persons on Public Assistance:					
Average monthly number of recipients.....	16,613	17,063	17,352	19,061	17,150
Highest monthly number of recipients.....	17,331	17,908	18,225	21,573	18,024
Lowest monthly number of recipients.....	16,183	16,149	16,791	17,952	16,395
Patients Receiving Service:					
Total number of patients.....	15,414	21,051	23,695	28,260	24,837
Number of indigent patients.....	11,161	14,115	14,386	16,912	15,022
Number of medically indigent patients..	4,253	6,936	9,309	11,348	9,815
% of patients medically indigent.....	28%	33%	39%	40%	40%
Expenditures:					
All Services	$366,184	$543,343	$556,863	$718,083	$661,126
Physicians' Services with % of total.....	284,831-78%	402,810-74%	393,504-71%	469,011-65%	448,780-68%
Dental Services with % of total.....	26,139- 7%	38,635- 7%	34,246- 6%	53,936- 8%	33,230- 5%
Pharmacy Services with % of total.....	52,969-14%	96,781-18%	123,197-22%	182,004-25%	170,021-26%
Sp. Diagnostic Services with % of total.....	2,245- 1%	5,117- 1%	5,916- 1%	13,132- 2%	9,095- 1%
Expenditures for Indigent Patients.....	$263,286	$348,795	$359,501	$440,924	$408,677
Expenditures for Med. Ind. Patients.....	102,898	194,548	197,362	277,159	252,449

% of Expenditures for Med. Ind. Patients..	28%	36%	35%	39%	38%
Average Cost Per Patient.....	$23.76	$25.81	$23.50	$25.41	$26.62
Average Cost Per Indigent Patient.....	23.59	24.71	24.99	26.07	27.21
Average Cost Per Med. Ind. Patient.....	24.19	28.05	21.20	24.42	25.72
Services Rendered:					
Physicians' Services—					
No. of physicians calls.....	97,366	135,400	147,166	180,840	172,692
% of home calls to total calls.....	34%	32%	32%	32%	32%
Average number of calls per patient....	7.1	7.0	7.2	7.5	8.1
Dental Services—					
Number of fillings made.....	3,143	4,148	4,624	6,351	4,723
Number of teeth extracted.....	4,882	7,734	8,079	11,604	7,058
Number of upper or lower dentures....	310	455	245	446	222
Pharmacy Service—					
Number of prescriptions filled.....	44,344	75,795	92,333	126,291	113,480
Average cost per prescription.....	$1.19	$1.26	$1.33	$1.44	$1.50
Professional Participants:					
Number of participating physicians.....	743	814	897	900	852
Number of participating dentists.....	264	302	316	343	280
Number of participating pharmacies.....	278	302	328	368	357

* All financial data on basis of billings rather than payments. Billings prorated at 70%, September-December 1950. Deductions carried by prorating totalled $50,370.

APPENDIX D

OTHER MEDICAL CARE PROGRAMS

While the administration of the County Medical Care Program is the major activity of the Bureau of Medical Services, the Bureau is also responsible for six other programs concerned with medical care. These are:

1. *Hospital Inpatient Program.*

This is Maryland's oldest medical care program. Under it State and City funds are provided to pay for the hospital care of patients declared indigent or medically indigent by the Department of Public Welfare. Fourteen general hospitals in Baltimore City, 22 in the Counties, and 8 providing special types of care participate in the Program. To each general hospital is allocated a maximum yearly sum all or a part of which must be earned by caring for state patients at a per diem rate which is the least of a) cost, b) billings to other patients for like services, or c) $12. The allotment to the eight special hospitals must be earned by caring for State patients at a per diem rate which is the lesser of a) cost or b) $3.00. The per diem covers all hospital services including drugs.

The Inpatient Program has a budget from the State of $2,502,345. Baltimore City is making available this year approximately $400,000 for supplementing State funds in paying for the care of City residents.

The cost of administering this program is estimated to be $29,000 a year.

2. *Hospital Outpatient Program.*

Under this Program Baltimore City and County Hospitals are paid for outpatient services to medically indigent persons. The State has made available $252,500 for this Program during the fiscal year 1952-53. $212,500 of this or any portion thereof is for the treatment of residents of Baltimore City. The City is required to make available for the same period an equal amount on a matching basis. Payment is made at the rate of $2.50 for each visit of a medically indigent patient to the dispensary. One half of this fee is paid from State funds and one half from City funds.

$40,000 of the total is made available to hospitals for outpatient services to County patients contingent upon the amount made available by individual counties on an equal matching basis. At the present time 12 counties are participating. A total of $25,139 has been allocated to these counties.

Eligibility for care under the Outpatient Program is determined by the local health department for county residents. For Baltimore City residents the various hospitals determine eligibility in accord with regulations established by the Department of Public Welfare.

This is the only program which provides care for the medically indigent of the City. It only provides dispensary care. Its administration is separate from that of the City Program for indigent and although the two offices collaborate there is a possibility of duplication.

3. *Chronic Hospitals.*

This program includes:

a) Planning for and supervision of construction or remodelling of hospitals.

b) Selection of suitable applications for admission to chronic hospitals.

c) Complete patient care in the hospitals.

d) Operation of two chronic hospitals at present.

4. *Cancer Control.*

Included in the program are:

a) Operation of cancer detection clinics;

b) Cancer education;

c) Research;

d) Provision of dressings.

5. *Hospital Licensing.*

This program inspects and licenses more than 200 institutions annually, including all voluntary and governmental (except Federal) hospitals and all nursing homes.

6. *Hospital Construction.*

This program has to do with administration of the Hill-Burton Act for the construction of hospitals and health centers. At present the program is supervising construction with a total value of approximately $4,000,000.

The Maryland Tuberculosis Hospitals with an annual budget of $3,000,000 is administered by the Bureau of Tuberculosis of the State Department of Health.

APPENDIX E

MARYLAND STATE DEPARTMENT OF HEALTH
Bureau of Medical Services

COUNTY MEDICAL CARE PROGRAM

PAYMENTS BY COUNTY BY YEAR

TOTALS FOR ALL SERVICES
1947 — 1951

County	1947	1948	1949	1950	1951
Total Counties ..	$366,184	$543,344	$556,834	$717,937	$661,126
Allegany	36,488	65,234	62,783	103,712	89,783
Anne Arundel...	11,167	17,134	24,006	29,098	28,000
Baltimore	28,311	39,754	62,692	99,715	94,403
Calvert	6,137	5,479	4,924	5,689	6,701
Caroline	12,005	16,791	17,288	15,069	15,529
Carroll	11,639	14,772	15,840	24,780	31,143
Cecil	16,689	22,599	21,111	22,928	15,182
Charles	10,584	10,189	11,250	10,384	10,157
Dorchester	14,834	23,247	23,867	40,455	37,513
Frederick	21,754	32,228	31,425	36,326	31,957
Garrett	14,398	27,169	34,454	47,948	34,133
Harford	15,528	24,463	16,896	24,895	24,691
Howard	5,913	9,095	9,226	11,067	10,484
Kent	3,747	4,690	3,956	4,852	4,079
Montgomery	24,359	40,584	48,989	49,307	45,381
Prince George's..	22,079	22,390	26,213	29,441	21,475
Queen Anne's ...	6,374	9,168	9,508	12,927	11,985
St. Mary's	5,362	8,991	7,768	9,860	11,610
Somerset	21,622	30,747	21,978	25,940	30,607
Talbot	6,172	8,800	7,026	9,532	9,482
Washington	36,358	62,705	52,486	58,961	54,892
Wicomico	22,423	28,946	24,975	28,792	26,400
Worcester	12,242	18,169	18,174	16,248	15,537

REPORT NO. 2

REVIEW OF THE MEDICAL CARE PLAN OF BALTIMORE CITY

INTRODUCTION

In August, 1944 the Committee on Medical Care of the Maryland State Planning Commission appointed a subcommittee under the chairmanship of Dr. Lowell J. Reed, to be known as the Committee to Study the Medical Care Needs in Baltimore.*

This Committee was created for the purpose of making a survey of needs in Baltimore City and preparing a plan for organizing and administering a city medical care program.

The Committee's Interim Report, presented in December, 1946, called attention to the pressing problem of medical care for recipients of public assistance and others in low economic groups. It noted that lack of an organized plan had resulted in the development of many deficiencies in the medical services provided by the Department of Public Welfare for these groups.

Dr. Reed's Committee recommended that a specific plan be adopted to meet the medical care needs of the welfare population of Baltimore City, and as soon as the Program was caring for the entire public assistance load, it might be extended to include the medically indigent.

It was suggested that the City Health Department assume community leadership in the coordination of medical facilities and establish in the Health Department a Medical Care Section.

On the basis of its survey the Committee presented a plan for organizing a medical care program for the city. Its ulti-

* The events which led up to this study have been set forth in the First Report of the Committee to Review the Medical Care Program.

mate objective was to provide the welfare group in the city continuous medical care comprising preventive, diagnostic and therapeutic services, and such auxiliary services in the field of dentistry, nursing and rehabilitation as are feasible.

The plan suggested the organization of medical centers associated with existing hospitals, thus to provide a system of home and ambulatory medical care through the integration of the facilities of the hospital dispensary and the services of the physicians practicing in the area.

After outlining the specific plan, the payment for medical services was to be as follows:

Payment for services of the Medical Center would be based on the number of public assistance clients assigned to it. Payment to the participating physicians would follow the same principle and be based on the number of clients selecting the physician for service. This capitation concept of payment was recommended by the Committee for several reasons, among which were a) that this plan would permit greater freedom in the referral of any individual to his personal physician by the Medical Center, and by the physician to the Center as the medical condition of the patient requires; and b) that this plan would simplify the administration of the program and reduce to a minimum the paper work that the general practitioner might be called upon to undertake.

In transmitting the Report to the Maryland State Planning Commission the Committee on Medical Care recommended that the Plan be adopted and that legislation be enacted to permit the State Board of Health to transfer available funds to the City of Baltimore for support of the Program, to be administered by the Baltimore City Health Department.

The Committee on Medical Care felt that the proposed Plan not only would offer to the indigent a more complete form of medical care than any heretofore available, but also would bring into working affiliation practicing physicians, hospital outpatient department, and the health department

clinics. Thus, a most desirable coordination of medical resources would be achieved, which was at that time seriously lacking. The contacts and conferences between physicians engaged in general practice, those working in hospitals and those associated with the City Health Department would have a distinct educational value and tend thus to raise the level of medical care for the whole community.

At its 1947 session, the General Assembly authorized the administration and financing of the Program under the Commissioner of Health of Baltimore City. This new legislation became effective on June 1, 1947.

BALTIMORE CITY MEDICAL CARE PLAN

A. How the Baltimore Medical Care Program Operates

The Baltimore Medical Care Plan was set up to provide medical care to the recipients of public assistance in Baltimore City. It depends on the cooperative action of the Department of Public Welfare, the City Health Department, a group of six hospitals and the medical profession of the city.

It is financed by annual appropriations of the General Assembly to the Mayor and City Council through the State Department of Health.

The Budget provides for the payment to certain hospitals, physicians, dental clinics and pharmacists for medical services rendered to the indigent who qualify under the regulations. Physicians, hospitals and dental clinics are paid on a capitation basis quarterly, in advance. Drugs are paid for on a basis of wholesale cost, plus a fixed markup.

The Program is administered by the Medical Care Section of the City Health Department. Administrative functions include contracting with hospitals for special Medical Care Clinics, the assignment to a clinic of each client referred by the Department of Public Welfare, maintenance of a necessary system of records, processing and certification for pay-

ment of bills for drugs and capitation fees to hospitals and physicians and general supervision of the operation of the Program.

The staff of the Medical Care Section includes a director, an assistant to the director, one secretary-stenographer, one senior stenographer, four clerks and two key-punch operators.

The Baltimore City Advisory Committee on Medical Care was created to review the Program and make recommendations regarding policy to the Health Commissioner. Its 20 members appointed by the Commissioner are representative of professional and civic groups. The Committee meets two or three times a year.

The professional and lay staff of the six Medical Care Clinics are employed and paid directly by the respective hospitals. The City Health Department has no administrative jurisdiction over the personnel of the various clinics.

Each individual who is accepted by the Department of Public Welfare for relief — public assistance — is given a detailed explanation of the services available under the Program and is urged to take advantage of them. His name is referred routinely to the Medical Care Section of the City Health Department. Upon receipt of the referral, the Section checks back against its records to determine if this individual has had previous contact. If so, he is reassigned to the same clinic under which he received treatment previously. If there has been no previous contact, he is generally assigned acording to the geographical location of his residence. If he has had previous contact with one of the hospital outpatient departments, he is reassigned to that particular clinic.

The client is given a medical care number and a permanent record is opened for him in the Health Department files, and the Medical Care Clinic to which he is allocated is notified by mail of the assignment. The client is then sent an explanatory letter and pamphlet and is informed that he has been assigned to a certain clinic. He is told to report on a given

day and hour for further instruction or examination at the clinic.

If the welfare client keeps his appointment, which about 60% of them do, a permanent record is opened under his name in the clinic files and on his first visit he is given such examination and treatment as may be urgently needed. He is asked to choose a physician who will care for him. If his usual family doctor, after a request from the clinic, refuses to accept him on the plan, the client will continue to make selections from the doctors he knows or from a list of participating physicians until he is provided for.

The Medical Care Clinic then notifies the physician that this particular person has been assigned to him and also notifies the Health Department that the patient has registered at the clinic and has been assigned to a certain doctor.

Some 40% fail to respond to the first notification sent out by the Health Department and do not keep their appointments at the clinic. After a reasonable lapse of time, the clinic sends a second notice to the client, giving him another appointment. Of those who receive the second notice, about one half report, leaving some 20% of those originally assigned who do not come in.

In some of the clinics, it is customary to give the client on his first visit an appointment to return for a physical examination. It is understood, of course, that the whole family is assigned to the clinic and not just the head of the family.

Any information concerning the client which the clinic gathers, either through a history, through physical examination or laboratory examination, is transmitted to the family physician to whom he has been assigned. If, at any time during his care of a particular patient, the family physician feels the need of consultation, special treatment or special examination, he may refer the patient to the Medical Care Clinic, with a request that certain procedures be carried out.

The clinic reports its findings and services back to the family physician. Occasionally, patients who are emotionally disturbed and thus difficult to handle, are treated in the clinic and are not referred to private physicians.

As soon as a family has been assigned to a clinic, the clinic begins to receive payment for its care at the rate of $10.00 per year for each individual assigned. This is paid quarterly, in advance. The clinic or hospital is allowed, in addition, $1.00 per person per year to cover emergency dental services.

From the day the indigent family is registered with a private physician, he begins to receive compensation at the rate of $7.00 per person per year, paid quarterly, in advance.

Eligibility for public assistance automatically qualifies for public medical care. Families dropped from the welfare rolls are no longer eligible for inclusion on the Program. They are not cut off immediately, however, but continue to receive care for a period of some three months on the average.

Medical care rolls are checked against public welfare rolls every six months.

The Health Department issues an identification card for each client, good for the remainder of the current half year ending on June 30, or December 31. Cards are automatically renewed every six months for as long as the patient is on the rolls.

If the clinic or the family physician wishes to prescribe medication for a patient, a prescription is written on a standard form, and is filled at the neighborhood pharmacy. The pharmacy sends the bill to the Health Department for payment.

At the present time, the City Health Department has contracts for special Medical Care Clinics with six hospitals.

The Medical Care Clinics have an administrative and professional responsibility to the Program. Administrative

functions include registration of public assistance clients who are assigned by the Medical Care Section; recruitment of local physicians to participate in the Program; the maintenance of a permanent detailed record on each client; arrangement for the initial physical examination and for subsequent special examinations, consultations, or treatments; and furnishing to the local participating physicians reports on examinations, consultations and treatment. Each clinic also supplies the Baltimore City Health Department with detailed statistical reports at regular intervals.

Professional responsibilities of the clinics include a general medical examination and formulation of a program of treatment for each person assigned to the clinic. The clinic also provides consultation service and special studies when requested by a participating physician, either by its own staff, or through arrangement with the outpatient department of the hospital. A considerable amount of treatment is given to patients requiring repeated medication over an extended period; to emergency cases when the family doctor is not available; to patients who have not been assigned to a doctor; and to difficult patients.

Procedures for handling assignments, appointments, registrations and reports are essentially the same in the six clinics. There is no standardization of administration of the professional function of the clinic. Each hospital has worked out a plan which is suited to its clinical facilities and administration.

Four of the clinics are in the same building with or in close proximity to the hospital outpatient department. Two are in nearby separate buildings. Each operates five days a week,* with a full-time staff, depending in number on the quota of patients allotted. In only one clinic is the director full-time. The director's duties and the amount of time he spends at the clinic varies among the six clinics.

* Emergency care is available 24 hours a day every day at the accident room of each hospital.

In five clinics part-time physicians do the routine physical examinations and a certain amount of treatment. At Sinai, all clinical services are provided in the outpatient department. Consultation in the specialties are referred to the outpatient departments in five of the clinics.

When the Program was organized, committees were set up at each clinic to handle grievances of physicians and clients and to act in an advisory capacity to the director. Complaints are rare, and there has been little need for this type of service.

When the Program was put into effect in 1948, the estimation of the total caseload was based on the number of persons who were at that time on the rolls of the Department of Public Welfare. The number was 22,000. Distribution of these persons among the various Medical Care Clinics was based, in turn, on the caseloads of the outpatient department of each of these hospitals, prior to the inauguration of the Program. The Johns Hopkins Hospital Dispensary at that time was caring for something more than 50% of all outpatients in Baltimore City. The minimum quota assigned to it by contract was 10,000. The University Hospital, which was second, was assigned 4,000.

Table I gives the minimum quota of each of the six Medical Care Clinics and the number of welfare clients they were carrying on their rolls in September of 1952.

The assignment of welfare recipients to the Medical Care Clinics began in August, 1948. The number of persons registered with the clinics increased slowly, and it was not until December, 1949 that facilities were available to care for the contractual minimum of 22,000 patients.

During the first months of the service, the budget allowances were greater than the needs. Certain economies were possible and a considerable saving took place. This allowed, in 1950, an increase in the quota which reached 29,302 assigned people in June of 1950.

TABLE I.

List Of Medical Care Clinics, Contractual Quotas, And Welfare Clients Assigned To Each

Name of Clinic	*Date First Contract Signed*	*Contractual Minimum Patient Quota*	*Individuals Registered As Of September 30, 1952*
Johns Hopkins Hospital	June 16, 1948	10,000	11,275
University Hospital....	June 16, 1948	4,000	4,529
South Balto. Gen. Hosp.	April 1, 1949	2,500	2,744
Sinai Hospital.....	May 1, 1949	1,000	1,698
Provident Hospital	June 1, 1949	2,500	2,904
Mercy Hospital.....	Dec. 1, 1949	2,000	2,327
Total.....		22,000	25,477

For the last six months of the fiscal year, 1950-51, it was necessary to reduce the number of assigned persons to the minimum quota of 22,000 as additional resources had been expended. This marked the beginning of the period when the caseload was geared to the budget appropriation, and the Program was handling the number of patients originally estimated to be the minimum.

For the current fiscal year, July 1, 1952 to June 30, 1953, the Baltimore City Medical Care Plan has received an addition to its appropriation, making it possible to raise the number of persons assigned to 25,000.

At no period, except from May to December, 1950 and for the current fiscal year, have there been sufficient funds to provide medical care for every person on the Baltimore City relief rolls.

Medical Care Clinics and physicians report quarterly to the Health Department on the number of services rendered.

The Medical Care Section devotes most of its activity to administration. It has little to do with the professional aspects of the Program. It has little contact with the physicians, and its influence on the procedures in the clinics is indirect. Clinic directors meet monthly with the Commissioner of

Health and the Section Director for discussion of the Program. Each clinic director has considerable autonomy. He is responsible to his hospital board.

B. Costs

In 1951, the total cost of the Medical Care Program was $569,045.28. Of this amount the state paid $546,962.28 and the city contributed $24,253 toward administrative expenses, in accord with its informal agreement with the state to provide 50% of central administrative costs.

The average monthly number of persons assigned to the Medical Care Clinics was 22,083.

The average cost per person assigned was $25.77. The average cost in the County Program was $23.83 per person on relief rolls.

Table II distributes this total expenditure into the various services.

TABLE II.

Distribution Of Expenditures By Type Of Service And Showing Amounts Per Person Assigned, 1951

Type of Service	*Expenditure*	*Expenditure Per Person Assigned*
Hospitals, Medical Care Clinics	$220,835.83	$10.00
Hospitals, Emergency Dental	22,083.58	1.00
Physicians	142,949.45	6.47
Pharmacies	137,923.42	6.25
Administration	45,253.00	2.05
Total	$569,045.28	$25.77

It is interesting to note that although the City and County Programs are organized on very different bases, the distribution of costs for the different services are for all intents and purposes identical, as illustrated in the following Table.

TABLE III.

PERCENT OF TOTAL EXPENDITURES, LESS ADMINISTRATION

Type of Service	*Baltimore City*	*Counties*
Medical Care Clinics plus physicians—City Physicians — County	69.0	68.0
Dental	4.2	5.0
Pharmacies	26.0	26.0

In 1951, the clinics gave an average of 2.2 services per client assigned and the doctor, an average of 2.4 services for each client registered with a physician.

As is true of all medical care programs where few prescribing restrictions are placed on the physician, the costs of drugs is the cause of considerable concern to the administrators of the Program. A recent report on the use of drugs in the Baltimore City Program* reveals that 55% of the prescriptions examined were for proprietary drugs; in some groups the proportion was as high as 85%. The report says that a reduction of $9,000 (6%) in the total drug bill for 1951 would have occurred, if official drugs had been used, instead of proprietary preparations. Over-prescribing and the use of "non-acceptable" drugs are factors in the high cost of medication. The report concludes that costs might be reduced by a) prescribing official drugs instead of proprietary preparations; b) limiting, in prescription writing, the duration of treatment; c) requiring the use of a formulary** whenever possible; d) including an educational program for prescription writing; e) educating physicians and pharmacists as to their responsibilities in the Medical Care Program.

Administrative costs — operation of the Medical Care Section only — amounted to 8% of total 1951 expenditures.

* "Prescribing, an Index to the Quality of Medical Care," Furstenberg, Tabuck, Goldberg, Davis. Presented at the Eighteenth Annual Meeting, APHA, Oct., 1952.

** Prescribed list of recipes, formulas, prescriptions and drugs.

One advantage of the capitation plan is that bookkeeping and administrative costs are at a minimum and only bills for drugs need complicated processing. There is no opportunity for unlimited charges for physicians' services, and it is possible to anticipate future expenditures with much more accuracy than is the case with the County Program.

Two hundred and eighty-six physicians were participating in the Program as of July 1, 1952. The table below shows the distribution according to the number of patients each doctor is caring for.

TABLE IV.

BALTIMORE CITY PHYSICIANS PARTICIPATING

No. of Patients Per Physician	*Number of Physicians*	*Percent of All Physicians*	*Cumulative Percent of All Physicians*
Total	286		
1	54	18.8	...
2-5	65	22.7	41.5
6-10	40	14.0	55.5
11-25	31	10.8	66.3
26-50	28	9.8	76.1
51-100	16	5.6	81.7
101-200	17	5.9	87.6
201-300	18	6.3	93.9
301-400	7	2.4	96.3
401-500	4	1.4	97.7
501-600	2	.7	98.4
601-700	1	.3	98.7
701-800	2	.7	99.4
801-900	...	...	...
901-1000	1	.3	99.7

Seventy-two percent of the doctors have less than 50 patients and 52%, from one to ten patients. Most of these are carrying a few patients they have always cared for, and the majority of doctors do not have offices in those areas where the indigents are concentrated.

Each hospital, where there is a Medical Care Clinic, provides emergency dental services to persons on the Medical

Care Program. This service is limited and consists only of extractions to relieve pain or remove infection. The hospitals are paid $1.00 per assigned patient per year for emergency dental services.

The Baltimore Medical Care Program makes no provision for the care of the medically indigent. If this group is included at some future date, it is likely that the first to be cared for will be those most recently dropped from the public assistance rolls and consequently ineligible for the Program. The present arrangement works a hardship on families with a medical care problem. When their public assistance stops, they must — after an average interval of three months — seek medical attention from their family physician or in one of the outpatient departments. The patient must pay the doctor and also the outpatient department unless he can qualify for the Outpatient Program. In any case he will have to find money for his drugs.

It is possible that a closer coordination of the various medical care programs would help correct this situation. It would also eliminate duplications which are said to occur occasionally.

At present the Department of Public Welfare's 1,000 children in foster homes receive their medical care through an arrangement with the City Hospitals. Public welfare and health authorities feel that facilities for the care of this important group should be enlarged to include the services of a family physician and drugs. This can be brought about by including foster children in the Program. The additional cost would not be appreciable.

C. Efficiency

The Baltimore City Medical Care Program was created as a solution, based on sound professional procedures, to the problem of providing medical attention for the city's relief load of some 22,000 persons.

It was based on exhaustive studies and profound thinking on the part of a group of men well qualified for the task.

It is now running smoothly and providing medical care for all families on the public welfare rolls.

This survey has disclosed no evidence of marked inefficiency in the operation of the Program.

With a minimum of delay, families accepted for any type of public assistance (except foster child care) are certified to the City Health Department as eligible for the Program.

The Health Department's Medical Care Section has set up the machinery for rapid assignment of each family to one of the six Medical Care Clinics.

Its system of records is efficient and adequate for bookkeeping needs.

The efficiency of that phase of the client's progress toward medical attention which begins with his assignment to a Medical Care Clinic varies considerably. It depends directly on the cooperation of the client. If he reports and keeps his appointments as directed, he will soon have the initial services which the Medical Care Clinic can give him and be registered with a family doctor for his general care. Necessary drugs are provided, and if he needs to see a specialist or have a particular test made, the service is furnished through the clinic and his doctor is notified of the results. Should hospitalization be necessary, the clinic often makes the arrangements.

The various clauses of the contract between the City Health Department and each hospital are being carried out with three exceptions. One has to do with consultation services in the various fields which the hospitals are expected to make available. At Provident Hospital the organization of the outpatient department is such that consultation cannot be provided. The Medical Care Clinic makes the arrangements by calling in a specialist for each examination, or send-

ing the patients to outpatient departments of other hospitals. This lack of facilities at Provident Hospital reduces, considerably, the advantages provided by other clinics because of their location in or near a hospital.

The contract stipulates that the Medical Care Clinic shall carry out a general medical examination and formulate a program of medical care for each public assistance client assigned and registered at the clinic for a period of six months or more. The extent to which this condition has been met varies considerably from clinic to clinic. The survey found that no statistics were available as to just what proportion of indigents registered at the clinic had been given a physical examination. Possibly, it ranges between 60% and 80%.*

One reason for this discrepancy is that clients do not keep their appointments for physical examinations when they are not suffering from any illnesses; another, is that clinic directors are not in agreement on how much of an examination should be given and how often. This particular clause of the contract was included, because it was thought to be important from a preventive medicine point of view, useful to the participating physician, and valuable for uncovering hitherto unknown pathological conditions. Whether or not these hopes have been realized in the light of the experience of the Program has not been determined. No statistical analysis was obtained by this Survey.

The administrators of the Program should evaluate this procedure and on the basis of studies, determine the minimum type of examination which can be carried out by all clinics; which will uncover all but the most obscure pathology; and which will be neither so costly or time consuming as to preclude the possibility of applying it to more than 60% of the assigned persons.

The contract also provides that the Director of the Medical Care Clinic shall make every reasonable effort to find a

* The Medical Care Section is in the process of determining the proportion of unexamined clients in each clinic.

physician who will care for each patient registered at the clinic. Through a combination of circumstances, it has not always been possible to carry out this clause of the contract. At one time, there were scattered through the various clinics 2,000 patients who had not been assigned to physicians. By November, 1952, this number had been reduced to 673. Although this represents only 3% of total patients assigned to the six clinics, in one clinic the director has been unable to find physicians for 13% of his assigned patients. Most of these unregistered clients are scattered throughout areas where the population is in the middle or higher income group and where the neighborhood general practitioners are relatively few and are completely occupied with the care of private patients. These doctors are too busy to accept patients from the Medical Care Program, and in many instances, they are averse to having them in their offices.

It is the task of the clinic director to find a family physician for each of his patients. How he should proceed is a problem which might be solved by the combined efforts of the six clinic directors and the Medical Care Section in the City Health Department.

This survey has made no effort to measure the quality of medical care. However, it is worthwhile to report the opinions of some of those who are closely associated with the operation of the Program and have a firsthand knowledge of what happens to individual patients. There is general acceptance of the Plan as a satisfactory method of providing good medical care for the indigent population. Some doctors, more nonparticipants than participants, object to the capitation aspect as being a trend towards socialism. For this reason, and because the fee is small and not attractive to some physicians, the bulk of the clients are registered with doctors whose practice is predominantly in those congested poor areas of the city from which come most of the people on public welfare. Hospital affiliation is not available to every doctor, nor do they have time or opportunity for professional experience in hospital outpatient departments. The Medical Care Clinic

directors say that there is a wide variation in the quality of care which the neighborhood physicians provide and, in some instances, the clinic is called on for services which should have been given by the general practitioner. Some clinic directors find it difficult to maintain high professional standards with the present arrangement.

On the other hand, there are also variations in the way the different clinics function. Nearly half of the participating physicians interviewed are critical of the clinics in regard to delays or failures in reporting on physicial examinations or consultations.

It is inevitable that a certain amount of poor medicine will be practiced under this Plan, as is probably the case for similarly situated patients who are privately treated. The welfare patient is safeguarded, however, to a considerable extent in that his clinic complements the work of the family physician and often takes over the responsibility of providing most of the treatment.

There is a feeling that perhaps a little too much was expected of the Program by its planners. Its primary objective of providing good care for the indigent sick is attained. It is doubtful that it can bring about general improvement in the practice of medicine or change the professional habits of the 100 doctors, each of whom cares for 25 or more medical care clients. If the administrators of the Program are dissatisfied with the quality of care which is being given by the neighborhood physicians and if they feel it is essential that quality be improved, the problem must be handed to the City and State Medical Societies for solution. Otherwise, the present system of free choice of physician may be replaced by a plan which gives the Medical Care Clinic the authority to select its neighborhood doctors.

The general impression resulting from this survey is that the Baltimore City Medical Care Program is functioning in an efficient manner and, on the whole, is generally satisfac-

tory to clients, Department of Public Welfare, City Health Department, Medical Care Clinics and physicians.

Former minor difficulties concerned with the flow of reports and records from one department to another have largely been eliminated. The system is complicated enough to require a very thorough understanding of the whole set-up by each administrative participant. There must exist a close working relationship, if the Program is to run smoothly.

It is doubtful that this can be brought about by a large advisory committee composed of key people, meeting at irregular intervals. Those who run the Program, from Public Welfare to family physician, are the logical people to develop its procedures. The Section of Medical Care of the City Health Department, whose present function is largely clerical and bill-paying, should take the lead as administrator of the Program in bringing about a solution of the various problems which influence efficiency.

As is true of the County Program, not enough attention has been paid to instructing clients, case workers, family physicians and medical care clinic staffs as to extent and limitations of services, individual responsibilities and the broad objectives of the Program in relation to Baltimore's public health and welfare.

D. Social Implications

In this Survey public welfare officials, public health officers, hospital directors, clinic directors, physicians and recipients of public assistance have been interviewed. The attitude of those who participate in any way in the Program is almost without exception strongly favorable.

The participating physicians approve of the Program and think it works well. Some complain of the low fee; many say they have medical care patients who make unusual demands; some think that clinics could improve their services to the physician; a number are appreciative of the opportunity for

improving their own medical knowledge; and only one of those interviewed was definitely opposed to the Program.

Prior to 1948, there was no organized program of medical care for the indigent of Baltimore City. When illness occurred, the great majority sought treatment as they had always done in one of the hospital outpatient departments. Other than spend some $23,000 a year for drugs, the Department of Public Welfare took no responsibility for medical care. There was no chance for preventive work or rehabilitation; curative medicine was haphazard, with little or no care in the home. Without doubt, the sick poor suffered and some died for lack of medical attention. In the face of steadily rising costs and falling incomes, physicians, outpatient departments and hospitals were carrying the load without adequate compensation.

Today, every sick welfare client who wants it, can have medical attention. The Program makes available to him a family physician, a consulting clinic, and the medicine he needs. It provides prevention and rehabilitation, as well as curative service. The physician and clinic are now paid for their work and both are relieved of a considerable portion of the charity load previously borne.

The Program has removed for the indigent group of the population, the financial obstacle to calling the doctor early in illness. Proper care during the initial stages of the more common diseases will shorten duration and reduce the need for expensive hospital care.

This Program was planned on the assumption that the family doctor selected by the welfare client should provide the bulk of the medical service to this group. It was the belief that this arrangement would benefit client, doctor and hospital and raise the quality of general medical care by: a) Establishing the patient-physician relationship for families who had always been cared for by outpatient departments; b) providing for medical attention in the home; c) giving non-affiliated doctors an opportunity for connection with a large outpatient department and the educational benefits of its

consultations and laboratory examinations; d) reducing the load on outpatient departments; e) keeping the practice of medicine in the hands of the general practitioner.

Doubt is expressed generally that the participating physicians have benefited educationally to any marked degree. Opportunity for close collaboration with the clinics is freely available, but relatively few take advantage of it, as they have neither the time nor inclination. Unfruitful attempts have been made by two clinics to bring the neighborhood physicians into closer working relationship with the clinic—perhaps the clinical directors were too easily discouraged.

The City Health Department is not pessimistic over the failure of wholesale acceptance of these opportunities by the neighborhood practitioners. It feels that four years is insufficient for drawing conclusions. The Plan should be allowed to go on for a much longer period before changes in fundamental philosophy and basic policy are instituted.

It is doubtful that the system has reduced the load on outpatient departments. The rise in demand for medical care is parallel to the increase in population. The number of people treated at the Johns Hopkins Outpatient Department depends on the capacity of the existing facilities. There is always more demand than can be accommodated. On the other hand, the Program has brought a considerable financial relief to the six hospitals. Two of these, however, say that the capitation fee does not meet their costs and another wants its quota increased. With these exceptions, there is general satisfaction with the Program on the part of participating hospitals.

Medical Education

There is dissatisfaction in medical school circles throughout the country with the present program of medical education. Students are trained in the hospital and outpatient department environment; they have no opportunity to know, firsthand, the home surroundings of their cases or the social

factors in these illnesses; they are inadequately prepared to go into general practice; and they do not understand their future responsibilities in relation to the social trends of today's medicine. There is a need for more physicians and for more suitable training. A number of medical schools have set about improving their practical teaching by organizing extern services and assuming responsibility for the home medical care of certain sections of the population served by their hospitals. The growing dearth of clinical material for teaching purposes makes it necessary for some of these plans to include public medical care clients.

A plan for using the Baltimore Program for teaching purposes is being discussed by those who have a dual interest in medical care and medical education. Its adoption might necessitate modification of the present clinic-physician-patient working relationship in the teaching hospital Medical Care Clinics. It would seem that the use of the Program for training future physicians would be far more productive from the educational standpoint, than is the present system.

Certainly, the quality of medical care for the city's charges would not suffer with such a plan.

CONCLUSIONS AND RECOMMENDATIONS

The Medical Care Program for Baltimore City was organized for the purpose of providing medical care for families who are recipients of public assistance.

The Program is financed by state funds. Medical and dental services are paid for by a capitation plan which differs from the fee-for-service system operating in the counties. Prescriptions are paid for on a cost-plus system, similar to that followed in the County Program.

The cost of central administration does not appear excessive for such a program.

There is no evidence of extravagance or abuse in expenditures. The caseload depends upon the number of persons certified for assistance by the Department of Public Welfare.

The City Program offers more facilities for medical care than does the County Program. It costs only 7% more per person on the welfare rolls.

Expenditures for drugs are considered high by those who administer the Program.

The Program provides an essential service. Its abandonment or curtailment would not only oblige the doctor to increase his free services, but would throw an intolerable burden on the outpatient departments of Baltimore's hospitals, forcing them to find additional aid or limit their services.

The operation of the Program is smooth, with little delay in providing for medical care for each new welfare family.

Administration is efficient and there is good collaboration among the various participating agencies.

The system of clinic-patient-physician relationship does not always work to the satisfaction of all participants.

Quality of medical care has not been determined. It is said to be generally good, but to vary considerably.

There are problems concerning the registration of clients with a family physician, the setting up of standard procedures in the medical care clinics, and the services of the family doctor, which need solving.

The Medical Care Section of the City Health Department performs its clerical functions efficiently, but it has little to do with the supervision of the professional aspects of the Program.

Statistical information on the operation of the Medical Care Clinics and on the services provided by family physicians is not available in sufficient detail to permit comparative analyses.

The 1952-53 appropriation is sufficient to provide medical care for all families on public assistance. The Program does not provide for foster children or medically indigent.

The possibility of using the Medical Care Program in the practical training of medical students is being discussed.

This Committee recommends that:*

1. The Medical Care Program for Baltimore City be continued without curtailment of appropriation.

2. The Medical Care Section of the City Health Department assume a more active role in the professional aspects of the Program, in addition to keeping close watch on its administration. This should include:

a) Making certain that each client is supplied with a family physician.

b) Setting up standard procedures for the six Medical Care Clinics.

c) Setting up a system which will allow for more comprehensive statistical reports at regular intervals.

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* I approve of the County Plan which is fee paid for service rendered. The patient selects the doctor. The doctor selects the patient.
I disapprove the city capitation plan.
(Signed) M. B. DAVIS, M.D.

d) Supervising the quality of the work of the individual physicians.

3. The Medical Care Section of the City Health Department draw up and put into operation a plan whereby the total cost of drugs might be reduced without diminishing the quality of care.

4. The Medical Care Section, with the assistance of clinic directors, develop and carry out a plan of active education on the objectives and operation of the Program for all participants.

5. The Program be extended to include foster children.

6. A study with recommendations be made of the existing facilities for care of the medically indigent, particularly those who, for one reason or another, have recently become ineligible for further general assistance.

7. The Committee on Medical Care of the Maryland State Planning Commission study ways and means whereby the Program might be integrated with medical school teaching and make specific recommendations in this regard to the two medical schools and the Medical Care Section of the City Health Department.

February 13, 1953

Baltimore, Maryland

These reports are respectfully submitted by:

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